State: *Indiana* ***Filing Company:*** *Anthem Insurance Companies, Inc.*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)*
Product Name: *IN 2015 - On- and Off-Exchange - IND*
Project Name/Number: */*

Filing at a Glance

Company:	Anthem Insurance Companies, Inc.
Product Name:	IN 2015 - On- and Off-Exchange - IND
State:	Indiana
TOI:	H16I Individual Health - Major Medical
Sub-TOI:	H16I.005B Individual - Point-of-Service (POS)
Filing Type:	Form/Rate
Date Submitted:	05/09/2014
SERFF Tr Num:	AWLP-129529773
SERFF Status:	Closed-Approved
State Tr Num:	IN_ONHIX_HMHS(1/15)
State Status:	
Co Tr Num:	
Implementation Date Requested:	01/01/2015
Author(s):	Terry Burns, Traci Rayman, Troy Wright, Paula Lewis-Lee, Valerie Stern, Timothy Tabler, Michelle Brown, Aaron Smith, Pak Ko, Terry Burns, Johnny Ko, Christopher Murrah, Wilson Wang, Judy Ding
Reviewer(s):	Kim Isles (primary), Karl Knable
Disposition Date:	08/29/2014
Disposition Status:	Approved
Implementation Date:	01/01/2015

State Filing Description:
INMM

State: *Indiana* **Filing Company:** *Anthem Insurance Companies, Inc.*
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Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact: 9.65%

Deemer Date:
Submitted By: Christopher Murrah

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 08/29/2014
State Status Changed: 08/20/2014
Created By: Christopher Murrah
Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: This submission includes both on-exchange products and off-exchange products.

Filing Description:

To the best of Anthem's knowledge and current understanding, this filing complies with the most recent regulations and related guidance. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required.

The purpose of this rate filing is to establish rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This rate filing is not intended to be used for other purposes.

REGARDING FORM FILING:
Attached, for your review and approval, are forms IN_ONHIX_HMHS(1/15), IN_ONHIX_PS(1/15), IN_OFFHIX_HMHS(1/15), and IN_OFFHIX_PS(1/15). These forms will be our HMO & POS contracts of coverage to be used for our non-grandfathered individual ON and OFF-exchange product offerings effective January 1, 2015. These forms are revised from our 2014 Exchange products, previously filed and approved by your department under the following SERFF numbers:

1. ANTA-129005311 (HMO and POS ON)
2. ANTA-129008359 (HMO and POS OFF)
3. ANTA-129138037 (MSP)

Upon approval, these forms will be used for any new and /or existing individual customers who choose to purchase or renew HMO or POS coverage ON or OFF-exchange.

Please note that the MSP-specific language has been incorporated into the HMO ON Exchange contract, rather than filing another separate MSP contract for your review. The MSP language is only contained in the Member Grievance section of the contract and the the language is notated with asterisks.

Also attached are:
1. Statement of variability to indicate how text in [brackets] will be used.
2. HMO Individual Company Filing Checklists.
3. Red-lined versions of contracts.

4. EHB Crosswalk Tools.
5. Readability Certification.

Please note that we certify that these forms meet readability requirements as required under the State of Indiana's insurance statutes.

Thank you for your assistance in this matter. If you have any questions regarding the form filings, please do not hesitate to contact me at (317) 852-8290, or Traci.Rayman@wellpoint.com.

Company and Contact

Filing Contact Information

Aaron Smith, AICI
220 Virginia Ave
Indianapolis, IN 46204

Aaron.Smith@Wellpoint.com
317-287-6452 [Phone]

Filing Company Information

Anthem Insurance Companies, Inc.
220 Virginia Ave
Indianapolis, IN 46204
(800) 331-1476 ext. [Phone]

CoCode: 28207
Group Code: 671
Group Name: WellPoint Inc Group
FEIN Number: 35-0781558

State of Domicile: Indiana
Company Type: Life, Accident, Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$175.00
Retaliatory?	No
Fee Explanation:	
Per Company:	Yes

Company	Amount	Date Processed	Transaction #
Anthem Insurance Companies, Inc.	$175.00	05/09/2014	82108367

SERFF Tracking #:	*AWLP-129529773*	***State Tracking #:***	*IN_ONHIX_HMHS(1/15)*	***Company Tracking #:***	

State:	*Indiana*	***Filing Company:***	*Anthem Insurance Companies, Inc.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)*		
Product Name:	*IN 2015 - On- and Off-Exchange - IND*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: IN_ONHIX_HMHS(1/15)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Indiana Individual HMO On Exchange Contract	IN_ONHIX_HMHS(1/15)	POL	Initial			IN_ONHIX_HMHS(1-15).pdf
2		Indiana Individual HMO Off Exchange Contract	IN_OFFHIX_HMHS(1/15)	POL	Initial			IN_OFFHIX_HMHS(1-15).pdf
3		Indiana Individual POS On Exchange Contract	IN_ONHIX_PS(1/15)	POL	Initial			IN_ONHIX_PS(1-15).pdf
4		Indiana Individual POS Off Exchange Contract	IN_OFFHIX_PS(1/15)	POL	Initial			IN_OFFHIX_PS(1-15).pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

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

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

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

Member Rights and Responsibilities

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

These are your rights and responsibilities:

You have the right to:

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

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

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

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,660]	$[0 - 13,200]

****

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

****

The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	Copayment	Coinsurance
Tier 1 (90-day supply)	$[0 - 50]	% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
**********		
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

****

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

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

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

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

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

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

Fixed and Rotary Wing Air Ambulance

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

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

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

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

You can get Covered Services from the following Providers:

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

Clinical Trials

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

Benefits are limited to the following trials:

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

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

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

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

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

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

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

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

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

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

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

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

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

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

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

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

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

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

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

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

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

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

Partial and Bridge Adjustments Covered when:

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

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a

benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

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

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

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

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

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

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.

- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

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

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

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

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

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:
  1) Allergy serum extracts;
  2) Chem strips, Glucometer, and lancets;
  3) Clinitest;

4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1) Replace all or part of a missing body part and its adjoining tissues; or
2) Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
7) Cochlear implants.
8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
9) Restoration prosthesis (composite facial prosthesis).
10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

Non-covered Prosthetic appliances include but are not limited to:

1) Dentures, replacing teeth or structures directly supporting teeth;
2) Dental appliances;
3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
  2) not solely for comfort or convenience.

  Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is

provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

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

Online Visits

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

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

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

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

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

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

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

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;

- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

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

Retail

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

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

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control.

Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

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

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

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

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

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

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

> **Helpful tip**: When Prescription Drugs are covered under this benefit, they will not also be covered under the “Where You Can Obtain Prescription Drugs” benefit. Also, if Prescription Drugs are covered under the “Where You Can Obtain Prescription Drugs” benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

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

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;
    - Type 2 Diabetes Mellitus;
    - Cholesterol;
    - Child or Adult obesity.
2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;

- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

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

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

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

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

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

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

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

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final

determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

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

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

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

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

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

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

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

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

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

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

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

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

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

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

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

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

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

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

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

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

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

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

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

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

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

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

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

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

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

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

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

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

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

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers.

    Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

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

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

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

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

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

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

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

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

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

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

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

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

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

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

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

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

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

Subscriber

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

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

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

    - Not be living in an institution
    - Be capable of indicating intent
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

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

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

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

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

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

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

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

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

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

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

Temporary custody is not sufficient to establish eligibility under this Contract.

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

Open Enrollment

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

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

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

Changes Affecting Eligibility and Special Enrollment

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

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

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

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

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

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

Qualified Medical Child Support Order

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

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

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

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

Notice of Changes

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

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

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

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

Statements and Forms

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

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

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

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

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

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

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

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

Loss of Eligibility

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

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

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

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

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

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

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

Cancellation

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

Removal of Members

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

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

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

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

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

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

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

How to Find a Provider in the Network

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

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

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

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

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

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

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

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

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

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

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

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

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

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

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

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

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

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

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

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

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

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

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

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

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

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

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

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

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

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

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Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

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

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

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

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

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

[Optional Language]
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Deductible Calculation

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

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

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

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

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

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

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

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

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

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

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

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

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

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

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

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

Explanation of Benefits

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

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

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a

claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

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

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

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

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

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

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

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

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

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

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

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

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

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

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

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

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

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

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

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

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

Decision and Notice Requirements

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

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

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

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

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

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

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

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

Health Plan Individual Case Management

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

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

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

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

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

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

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Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

An expedited request for external review from the U.S. Office of Personnel Management may be made at the same time as your request for an expedited appeal. See the 'Independent external review appeals' section for further information.

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or
    - a determination that a proposed service is Experimental/Investigational; or
2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one year after you are notified of the Appeal panel’s decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If you do not agree with Our decision, you are entitled to request an independent, external review within one year of Our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714

with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one that concerns an admission, availability of care, continued stay, or health care service for which you have received emergency services, but have not been discharged. A situation is also urgent if the standard External Review time frame would seriously jeopardize your life, health, or ability to regain maximum function. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review Our decision. If your claim was denied as not Medically Necessary or Experimental/Investigative, OPM will seek the binding opinion of an independent review organization (IRO). The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn Our decision, We will provide coverage or payment for your health care item or service and We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714 at any time. Additionally, the State of Indiana Department of Insurance may be able to help you file your appeal. Contact the Consumer Services Division of the Department of Insurance at (800) 622-4461 or (317) 232-2395, write to them at State of Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204 or electronically at www.ingov/idoi.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. In general, OPM will accept External Grievance requests filed within one year after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

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

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

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

COB DEFINITIONS

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

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

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

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

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

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

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

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

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

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

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

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

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

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

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

Reimbursement

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

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

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

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

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

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

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

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

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

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

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

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

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

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

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

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

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

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

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

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

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

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

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

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

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

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

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

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

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

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

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

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

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

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

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

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

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

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

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

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

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

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

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

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

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

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

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

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

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

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

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

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

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

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

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

Member Rights and Responsibilities

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

These are your rights and responsibilities:

You have the right to:

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

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

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

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,600]	$[0 - 13,200]

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If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

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The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	**Copayment**	**Coinsurance**
Tier 1 (90-day supply)	$[0 - 50]	[0 - 30]% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
**********		
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

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

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

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

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

Fixed and Rotary Wing Air Ambulance

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

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

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

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

You can get Covered Services from the following Providers:

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

Clinical Trials

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

Benefits are limited to the following trials:

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

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

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

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

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

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

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

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

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

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

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

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

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

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

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

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

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

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

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

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

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

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

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

Partial and Bridge Adjustments Covered when:

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

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a

benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

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

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

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

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

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

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.

- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

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

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

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

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

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain

Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;
  3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
  4) Artificial heart implants;
  5) Wigs (except as described above following cancer treatment.)

6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and

2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

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

Online Visits

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

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

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

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

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

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

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

Benefits are available for the following:

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

Where You Can Obtain Prescription Drugs

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

Retail

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

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

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on

the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

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

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

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

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

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

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

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

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

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

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

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

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

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

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

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

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize your benefits.

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

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

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

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

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

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

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

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

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

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

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

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

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

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

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

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

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

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

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

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

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

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

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

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

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

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

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

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

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

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

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

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

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

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

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

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers.

    Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

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

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

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

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

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

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

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

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

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

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

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

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

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

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

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

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

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

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

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

Temporary custody is not sufficient to establish eligibility under this Contract.

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

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

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

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

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

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

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

Notice of Changes

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

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

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

Statements and Forms

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

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

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

Termination of the Member

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

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

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

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

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

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

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

Cancellation

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

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

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

Refund of Premium

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

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

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

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

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

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

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

How to Find a Provider in the Network

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

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

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

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

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

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

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

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

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

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

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

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

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

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

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

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

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

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

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

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

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

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

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

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

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

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

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

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

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

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

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

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

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Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

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

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

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

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

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

[Optional Language]
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Deductible Calculation

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

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

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

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

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

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

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

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

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

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

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

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

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

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

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

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

Explanation of Benefits

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

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

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a

claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

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

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

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

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

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

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

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

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

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

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

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

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

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

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

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

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

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

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

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

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

Decision and Notice Requirements

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

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

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

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

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

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

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

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

Health Plan Individual Case Management

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

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

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

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

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

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

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

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

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

COB DEFINITIONS

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

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

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

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

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

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

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

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

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

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

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

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

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

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

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

Reimbursement

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

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

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

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

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

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

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

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

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

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

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

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

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

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

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription

Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

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

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

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

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

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

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

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

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

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

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

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

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

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

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

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

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

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

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

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

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

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

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

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

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

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

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

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);

    - Surgery;

    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:

- Is licensed as such, where required;
- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

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

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

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  - Provides skilled nursing and other services on a visiting basis in the Member's home; and

  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  - Skilled nursing services

  - Prescription Drugs

  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

  1. nursing care;

  2. rest care;

  3. extended care;

4. convalescent care;
5. care of the aged;
6. Custodial Care;
7. educational care;
8. treatment of Mental Health Disorders;
9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.
- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.
- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

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

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how

you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

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

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

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

Member Rights and Responsibilities

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

These are your rights and responsibilities:

You have the right to:

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

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

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

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Network Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

	Network		**Non-Network**	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Calendar year deductible	$[0 - 5,000]	$[0 - 10,000]	$[0 - 15,000]	$[0 - 30,000]
The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]	$[0 - 30,000]	$[0 - 60,000]

	Network		**Non-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services	$[0]	[0 - 40]%	$[0]	[0 - 40]%
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.			
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.			
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0-3] visits; care is then subject to Deductible and Coinsurance for subsequent	$[0 - 50]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
visits.				
Specialty Care Provider (SCP)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Other Office Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Emergency room visits (Copayment waived if admitted)	$[0 - 200]	[0 - 40]%	$[0 - 200]	[0 - 40]%
Urgent Care Center	$[0 - 50]	[0 - 40]%	$[0 - 50]	[0 - 40]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year, Network and Non-Network combined, and a maximum of [164] visits per Member, per lifetime Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospice Care	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospital Services				
Inpatient	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Maximum limit of [60] days per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Mental Health & Substance Abuse				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Outpatient facility	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient office visit	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Diagnostic tests				
Laboratory	$[0]	[0 - 40]%	$[0]	[0 - 60]%
MRI, CT, & PET scan	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Radiology	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Speech, Occupational, and Manipulation Therapy** Limited to a maximum of [20] visits per Member, per Calendar Year for physical therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for occupational therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for speech therapy, Network and Non-Network combined. Limited to a maximum of [12] visits per Member, per Calendar Year for manipulation therapy, Network and Non-Network combined. **Cardiac Rehabilitation** Limited to a maximum of [36] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home	$[0]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.				
Preventive Care Services Network Care not subject to Deductible	$0	0%	$[0]	[0 - 60]%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Surgery				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient treatment	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Ambulatory Surgical Center	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.		Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]% Covered transplant procedure charges at a Non-Network Transplant Provider Facility will NOT apply to

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
				your Out-of-Pocket Maximum.
Prescription Drugs	**Participating Pharmacy**		**Non-Participating Pharmacy**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Retail (30-day supply)				
Tier 1	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 2	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Tier 4	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).				
Mail Order				
Tier 1 (90-day supply)	$[0]	[0 - 40]% [after Calendar Year Deductible]	Not Covered	
Tier 2 (90-day supply)	$[0]	[0 - 40] % [after Calendar Year Deductible]	Not Covered	
Tier 3	$[0]	[0 - 40]% after Calendar Year	Not Covered	

Prescription Drugs	Participating Pharmacy		Non-Participating Pharmacy	
	Copayment	Coinsurance	Copayment	Coinsurance
(90-day supply) Tier 4 (30-day supply)	$[0]	Deductible [0 - 40]% after Calendar Year Deductible	Not Covered	
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, Participating Specialty Pharmacy, or Non-Participating Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.			

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance	Pediatric Non-Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%	[0 - 10]%
Basic Restorative Services	[0 - 40]%	[0 - 40]%
Oral Surgery Services	[0 - 50]%	[0 - 50]%
Endodontic Services	[0 - 50]%	[0 - 50]%
Periodontal Services	[0 - 50]%	[0 - 50]%
Major Restorative Services	[0 - 50]%	[0 - 50]%
Prosthodontic Services	[0 - 50]%	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period.	[0 - 50]%	[0 - 50]%

Pediatric Vision Services The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible.

	Network Copayment	**Non-Network Payment Allowance**
Routine Eye Exam	$[0]	$[30]
[One per Calendar Year]		
Standard Plastic Lenses*		
[One per Calendar Year]		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]
Progressive	$[0]	$[40]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.		
Frames* (formulary) This Plan offers a selection of covered frames.	$[0]	$[45]
[One per Calendar Year]		
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	$[Covered in Full]	$[210]
[One per Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the Plan will pay for the services.

****

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no

Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Contract. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

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

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

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

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

Fixed and Rotary Wing Air Ambulance

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

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

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

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

You can get Covered Services from the following Providers:

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

Clinical Trials

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

Benefits are limited to the following trials:

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

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

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

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

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

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

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

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

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

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

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

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

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

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

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

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

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

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

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

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

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

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

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

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

Partial and Bridge Adjustments Covered when:

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

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

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

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

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

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

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

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.

- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

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

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

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be

considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

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

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

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

Online Visits

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

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

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

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

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

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

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

Benefits are available for the following:

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

Where You Can Obtain Prescription Drugs

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

Retail

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

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

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on

the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

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

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

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

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

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

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

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

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

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

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

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

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

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

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

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

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize your benefits.

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

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

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

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

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

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

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

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

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

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

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

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

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

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for services rendered by Providers located outside the state of Indiana unless the services are for Emergency care, urgent care and ambulance services; or the services are approved in advance by Anthem.

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

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

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

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related

means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

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

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

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

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

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

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

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

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

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

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

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

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

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

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

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

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

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

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

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

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

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

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

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

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

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

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

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

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

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

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

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

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

Subscriber

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

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

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

    - Not be living in an institution
    - Be capable of indicating intent
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

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

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

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

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

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

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

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

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

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

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

Temporary custody is not sufficient to establish eligibility under this Contract.

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

Open Enrollment

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

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

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

Changes Affecting Eligibility and Special Enrollment

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

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

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

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

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

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

Qualified Medical Child Support Order

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

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

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

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

Notice of Changes

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

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

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

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

Statements and Forms

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

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

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

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

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

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

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

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

Loss of Eligibility

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

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

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

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

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

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

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

Cancellation

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

Removal of Members

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

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers located in the state of Indiana; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

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

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

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

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits**.

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

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

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

How to Find a Provider in the Network

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

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

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

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

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

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

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

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

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

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

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

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

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

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

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

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

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

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

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

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

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

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has

agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

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

For Covered Services you receive from a Non-Participating Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

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

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

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

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

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

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include but are not limited to:

- amounts over the Maximum Allowed Amount;
- amounts over any Contract maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

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

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

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

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Network Out-of-Pocket Limit is satisfied, no additional Network Coinsurance will be required for the remainder of the calendar year.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Coinsurance will be required for the remainder of the calendar year, except for out-of-Network Human Organ and Tissue Transplant services.

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

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Participating or Non-Participating Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan’s benefits or Cost-Share amounts may vary by the type of Provider you use.

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

In some instances, you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or

pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating Cost-Share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize you to go to an available Non-Participating Provider for that Covered Service and We agree that the network Cost-Share will apply.

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

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

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

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

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

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

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

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

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

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

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

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

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Contract. You must exhaust the Plan's appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Anthem covers only limited healthcare services received outside of Our Service Area. For example, Emergency or Urgent Care obtained out of Our Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual

obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment or Coinsurance stated in this Contract.

Whenever you obtain covered services or supplies outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

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

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for Emergency or Urgent Care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Our Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, we may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or

hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

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

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

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

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

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

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

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

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

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

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

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

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by a Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

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

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

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

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

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

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

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

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

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

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

Decision and Notice Requirements

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

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

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

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

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

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

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

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

Health Plan Individual Case Management

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

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

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

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

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

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

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

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

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

COB DEFINITIONS

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

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

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

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

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

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

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

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

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

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

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

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

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

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

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

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

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

Reimbursement

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

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

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

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

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

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

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

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

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

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

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

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

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

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

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

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

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

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

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

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

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

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

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

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

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

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

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

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

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

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

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

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

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

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

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

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

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

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

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

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

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

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

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

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

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

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

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

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

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

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

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

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

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

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

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

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

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

Member Rights and Responsibilities

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

These are your rights and responsibilities:

You have the right to:

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

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

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

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Network Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

	Network		**Non-Network**	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Calendar year deductible	$[0 - 5,000]	$[0 - 10,000]	$[0 - 15,000]	$[0 - 30,000]
The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]	$[0 - 30,000]	$[0 - 60,000]

	Network		**Non-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services	$[0]	[0 - 40]%	$[0]	[0 - 40]%
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.			
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.			
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0-3] visits; care is then subject to Deductible and Coinsurance for subsequent	$[0 - 50]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
visits.				
Specialty Care Provider (SCP)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Other Office Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Emergency room visits (Copayment waived if admitted)	$[0 - 200]	[0 - 40]%	$[0 - 200]	[0 - 40]%
Urgent Care Center	$[0 - 50]	[0 - 40]%	$[0 - 50]	[0 - 40]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year, Network and Non-Network combined, and a maximum of [164] visits per Member, per lifetime Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospice Care	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospital Services				
Inpatient	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Maximum limit of [60] days per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Mental Health & Substance Abuse				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Outpatient facility	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient office visit	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Diagnostic tests				
Laboratory	$[0]	[0 - 40]%	$[0]	[0 - 60]%
MRI, CT, & PET scan	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Radiology	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Speech, Occupational, and Manipulation Therapy** Limited to a maximum of [20] visits per Member, per Calendar Year for physical therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for occupational therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for speech therapy, Network and Non-Network combined. Limited to a maximum of [12] visits per Member, per Calendar Year for manipulation therapy, Network and Non-Network combined. **Cardiac Rehabilitation** Limited to a maximum of [36] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home	$[0]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.				
Preventive Care Services Network Care not subject to Deductible	$0	0%	$[0]	[0 - 60]%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Surgery				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient treatment	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Ambulatory Surgical Center	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.		Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]% Covered transplant procedure charges at a Non-Network Transplant Provider Facility will NOT apply to

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
				your Out-of-Pocket Maximum.
Prescription Drugs	**Participating Pharmacy**		**Non-Participating Pharmacy**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Retail (30-day supply)				
Tier 1	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 2	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Mail Order				
Tier 1 (90-day supply)	$[0]	[0 - 40]% [after Calendar Year Deductible]	Not Covered	
Tier 2 (90-day supply)	$[0]	[0 - 40] % [after Calendar Year Deductible]	Not Covered	
Tier 3	$[0]	[0 - 40]% after Calendar Year	Not Covered	

Prescription Drugs	Participating Pharmacy		Non-Participating Pharmacy	
	Copayment	Coinsurance	Copayment	Coinsurance
(90-day supply) Tier 4 (30-day supply)	$[0]	Deductible [0 - 40]% after Calendar Year Deductible	Not Covered	
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, Participating Specialty Pharmacy, or Non-Participating Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.			

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance	Pediatric Non-Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%	[0 - 10]%
Basic Restorative Services	[0 - 40]%	[0 - 40]%
Oral Surgery Services	[0 - 50]%	[0 - 50]%
Endodontic Services	[0 - 50]%	[0 - 50]%
Periodontal Services	[0 - 50]%	[0 - 50]%
Major Restorative Services	[0 - 50]%	[0 - 50]%
Prosthodontic Services	[0 - 50]%	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period.	[0 - 50]%	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible.

	Network Copayment	Non-Network Payment Allowance
Routine Eye Exam	$[0]	$[30]
[One per Calendar Year]		
Standard Plastic Lenses*		
[One per Calendar Year]		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]
Progressive	$[0]	$[40]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.		
Frames* (formulary) This Plan offers a selection of covered frames.	$[0]	$[45]
[One per Calendar Year]		
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	$[Covered in Full]	$[210]
[One per Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the Plan will pay for the services.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Contract. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

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

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

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

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

Fixed and Rotary Wing Air Ambulance

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

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

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

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

You can get Covered Services from the following Providers:

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

Clinical Trials

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

Benefits are limited to the following trials:

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

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

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

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

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

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

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

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

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

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

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

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

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

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

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

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

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

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

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

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

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

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

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

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

Partial and Bridge Adjustments Covered when:

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

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

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

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

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

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

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

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.

- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

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

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

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be

considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

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

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

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

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

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

Online Visits

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

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

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

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

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

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

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

Benefits are available for the following:

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

Where You Can Obtain Prescription Drugs

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

Retail

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

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

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

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

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

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on

the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

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

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

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

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

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

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

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

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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

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

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

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

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

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

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

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

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

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize your benefits.

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

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

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

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

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

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

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

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

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

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for services rendered by Providers located outside the state of Indiana unless the services are for Emergency care, urgent care and ambulance services; or the services are approved in advance by Anthem.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related

means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the “Covered Services” section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage’s benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond the Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications or other forms or statements the Plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

This section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers located in the state of Indiana; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits**.

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has

agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include but are not limited to:

- amounts over the Maximum Allowed Amount;
- amounts over any Contract maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Network Out-of-Pocket Limit is satisfied, no additional Network Coinsurance will be required for the remainder of the calendar year.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Coinsurance will be required for the remainder of the calendar year, except for out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Participating or Non-Participating Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan’s benefits or Cost-Share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances, you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or

pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating Cost-Share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize you to go to an available Non-Participating Provider for that Covered Service and We agree that the network Cost-Share will apply.

Your Plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost-Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, you may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Contract. You must exhaust the Plan's appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Anthem covers only limited healthcare services received outside of Our Service Area. For example, Emergency or Urgent Care obtained out of Our Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual

obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment or Coinsurance stated in this Contract.

Whenever you obtain covered services or supplies outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for Emergency or Urgent Care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Our Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, we may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or

hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by a Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription

Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs -- The term Generic Drugs means a Prescription Drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider -- A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:

- Is licensed as such, where required;
- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
  1. constituted, licensed, and operated as set forth in the laws that apply;
  2. equipped to provide low-risk maternity care;
  3. adequately staffed with qualified personnel who:
     a. provide care at childbirth;
     b. are practicing within the scope of their training and experience; and
     c. are licensed if required; and
  4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant -** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  - Provides skilled nursing and other services on a visiting basis in the Member's home; and

  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  - Skilled nursing services

  - Prescription Drugs

  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;

  2. rest care;

  3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how

you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

State: Indiana **Filing Company:** Anthem Insurance Companies, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IN 2015 - On- and Off-Exchange - IND
Project Name/Number: /

Rate Information

Rate data applies to filing.

Filing Method: File and Approve
Rate Change Type: Increase
Overall Percentage of Last Rate Revision: %
Effective Date of Last Rate Revision: 01/01/2014
Filing Method of Last Filing: File and Approve

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Anthem Insurance Companies, Inc.	Increase	2.530%	2.530%	$15,543,260	28,986	$630,180,517	11.900%	-9.900%

State: *Indiana* ***Filing Company:*** *Anthem Insurance Companies, Inc.*
TOI/Sub-TOI: *H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)*
Product Name: *IN 2015 - On- and Off-Exchange - IND*
Project Name/Number: */*

Rate Review Detail

COMPANY:

Company Name: Anthem Insurance Companies, Inc.
HHS Issuer Id: 17575

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
IN IND HMO and POS On-Exchange, IN IND HMO and POS Off-Exchange		17575-228677	41280

Trend Factors:

FORMS:

New Policy Forms: IN_ONHIX_HMHS(1/15), IN_OFFHIX_HMHS(1/15), IN_ONHIX_PS(1/15), IN_OFFHIX_PS(1/15)
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 1,362,788
Benefit Change: Increase
Percent Change Requested: Min: -9.9 Max: 11.9 Avg: 2.53

PRIOR RATE:

Total Earned Premium: 614,637,257.00
Total Incurred Claims: 489,568,202.00
Annual $: Min: 153.66 Max: 2,088.07 Avg: 451.01

REQUESTED RATE:

Projected Earned Premium: 630,180,517.00
Projected Incurred Claims: 505,866,978.00
Annual $: Min: 83.70 Max: 1,623.24 Avg: 462.42

State: Indiana **Filing Company:** Anthem Insurance Companies, Inc.
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)
Product Name: IN 2015 - On- and Off-Exchange - IND
Project Name/Number: /

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Response to 6/2 Objection		Other	Previous State Filing Number: Rate Action Other Explanation:	IND response to objection 06_02_14.pdf, Formulary Drug Tier Movement.pdf, Early Renewal Impact.pdf, Experience to Rating Morbidity.pdf, Medicaid Spend Down.pdf,
2		Response to 6/2 Objections Part II		Other	Previous State Filing Number: Rate Action Other Explanation:	Pediatric Dental.pdf, Pediatric Vision Cost & Utilization IND.pdf, Reinsurance.pdf, IN IND Index to Base dev.pdf, IND ON AV Screen Shots.pdf,
3		Response to 6/2 Objection Part III		Other	Previous State Filing Number: Rate Action Other Explanation:	IND OFF AV Screen Shots.zip,
4		Response to 7/1 Objection		Other	Previous State Filing Number: Rate Action Other Explanation:	IN Rx Counts By Class and Tier Exhibit.pdf, IN17575_2015_Rates_Template_IND_ON_OFF_(Serff).xlsm, Indiana Individual Actuarial Memo 6.5.14.pdf, URRT - IN - IND - G2001 - Submission 06 03 2014.xlsm,

SERFF Tracking #:	AWLP-129529773	**State Tracking #:**	IN_ONHIX_HMHS(1/15)	**Company Tracking #:**	

State:	Indiana	**Filing Company:**	Anthem Insurance Companies, Inc.
TOI/Sub-TOI:	H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)		
Product Name:	IN 2015 - On- and Off-Exchange - IND		
Project Name/Number:	/		

Attachment IND OFF AV Screen Shots.zip is not a PDF document and cannot be reproduced here.

Attachment IN17575_2015_Rates_Template_IND_ON_OFF_(Serff).xlsm is not a PDF document and cannot be reproduced here.

Attachment URRT - IN - IND - G2001 - Submission 06 03 2014.xlsm is not a PDF document and cannot be reproduced here.

Thank you for your inquiry dated 6/02/14.

1) *What are some examples of preventive Rx mentioned on Page 7?*

   Some examples of preventive OTC Rx are smoking cessation, aspirin, iron supplements, folic acid and fluoride supplements.

2) *Please provide additional explanation of what is involved with the Rx adjustments under the Changes in Benefits section?*

   Base experience data came from open-formulary plans with certain tiers assigned to each drug. The filing is for a product with a closed formulary, and even the covered formulary drugs could be on a different tier than they were in the base experience data. We reviewed our base experience drug class by drug class, looking at the tier and coverage situations in the base period as compared to the new tier and coverage situations and applied assumptions about how the utilization may shift scripts from certain drugs to certain other drugs. We then reviewed those assumptions with a group of WellPoint pharmacists to provide clinical input as to the appropriateness of those assumptions and made adjustments accordingly. The pharmacist review covered 75%-80% of the pharmacy spend, and we found that they suggested adjustments primarily in large classes with specific, unique characteristics, and in other situations felt that the initial assumptions did a good job of estimating movements, and so felt it was appropriate to use the initial assumptions on the remaining 20%-25% of the pharmacy spend. The Rx Adjustment is based on the difference between the mix of drugs observed in the base experience data and the tiers of those drugs as compared to the assumed mix of drugs and tiers under the closed formulary design for this filing.

3) *On page 8, you mention that Wakely calculated Anthem's relative risk to the market. Can you describe as to if Anthem was above or below the market and what the relativity was?*

   Based on the study conducted by Wakely Consulting, Anthem’s relative risk to the market was 1.01305, or approximately 1.3% higher than the market.

4) *What trend was used in 2013 for 2014 rates? What is the impact of the volatility provision?*

   The annual pricing trend used in the development of the 2014 ACA rates was 11.5%. The impact of the volatility provision with this rate filing is 2.4%.

5) *Please explain what the PMPM adjustments were due to the high cost drugs for treating Hepatitis C?*

   The PMPM adjustments due to the high cost drugs for treating Hepatitis C were $1.54 in 2014 and $3.29 in 2015.

6) *Please provide the impact to PMPM of the Pervasive Development Disorder mandate.*

We anticipate the cost of these members to be approximately $7,500 PMPM in 2015.

7) *With regard to Exhibit C, please explain how the future population factors were determined. In addition then, provide how the two average claim factors were used to get to the normalization factor.*

The average claim factors for the future population shown in Exhibit C are calculated as a member-weighted average of the claim factors for age/gender, area/network, and benefit plan, using the projected membership distribution assumptions in our pricing model.

The Normalization factors are the ratio of the Future Population and the Experience Period Population.

8) *You indicate in Exhibit D that the Rx Adjustments were for the impacts of moving drugs into different tiers, please provide a list with drugs that were moved showing where they were moved from and to.*

Please see "Formulary Drug Tier Movement.pdf" included with this response that provides the list of drugs moving into different tiers. Please note, the list provided represents the movement used in pricing and is current at this time, but is continually being re-evaluated and could change.

9) *In Exhibit D, you have a morbidity change of 1.1426, please show some detail around what impact all the items mentioned in the memorandum.*

The 14.26% referenced above consists of 3.22% for the impact of early renewal, -1.31% for experience to rating morbidity, 4.86% for Small Group to Individual morbidity, 1.49% for uninsured excess morbidity, 2.08% for uninsured pent-up demand and 3.25% for excluding Grandfathered business from Individual.

Early Renewal Impact – 3.22%

Please see "Early Renewal Impact.pdf" included with this response that provides additional detail related to the Early Renewal Impact.

Experience to Rating Morbidity – -1.31%

Please see "Experience to Rating Morbidity.pdf" included with this response that provides additional detail related to the Experience to Rating Morbidity.

Small Group to Individual Morbidity – 4.86%

We expect the morbidity in Individual to be slightly higher than Small Group in 2015. Individuals can make individual purchasing decisions that fit their needs, resulting in higher risk individuals being more likely to opt in than the lower risk population in 2015. On the other hand, the bigger Small Groups are less subject to adverse selection since the purchasing decision is being made at the group level, contributing to better average morbidity in Small Group.

Since we are using 2013 Small Group experience as the basis for developing 2015 Individual rates, we calculated an initial estimate of this difference by comparing the health status (based on risk score data) of smaller Small Groups to the health status of the total Small Group block. As we segmented Small Group members by group size (across all our states), we observed that groups of 1 had a health status that was almost 30% higher than the total Small Group block on average, groups of 2 had a health status that was 10% higher, and after that groups' health statuses are more in line with or lower than the block average. Across our states, risk scores for group sizes 2-5 were 3% higher than the total Small Group block (with state by state variation). We felt this subsection of Small Group represented the most reasonable approximation for the slightly higher morbidity we would expect in Individual in 2014 and specifically excluded groups of 1 because they exhibit the most anti-selective behavior as seen through their health status. For IN specifically, we applied the state specific distribution of Small Group members by group size (18% are in a 2-5 life group) to the enterprise average risk scores for those group sizes to generate the preliminary estimate of a 4.15% load.

In addition to the analysis of Small Group experience by group size, we also forecasted 2015 allowed claims costs for new members entering the 2014 ACA Individual market. We used applicant data from new WellPoint ACA applications through March 2014 to develop the forecast. Based on this additional information we decided to increase the preliminary 4.15% load by 0.68% to arrive at the final load of 4.86% (1.0415 * 1.0068 = 1.0486).

Uninsured Excess Morbidity – 1.49%

This adjustment is based on a CDC study on the health status and life styles of both currently insured and uninsured populations. Using data across all our states to increase credibility, we developed factors by age band to estimate the relative morbidity difference between the previously uninsured and insured (Excess Morbidity Factor in table below). Then we weighted this factor against the portion of the 2014 Individual block that we expected to come from Uninsured to develop a single Excess Morbidity Load of 1.0149 (see table below).

Age Band	Percent Previously Insured Members	Percent Previously Uninsured Members	Excess Morbidity Factor (CDC study)	Excess Morbidity Load
0-18	16%	5%	1.000	1.000
19-29	10%	5%	1.000	1.000
30-39	10%	5%	1.063	1.021
40-49	11%	6%	1.119	1.042
50-64	21%	12%	1.039	1.015
Total	67%	33%	1.039	**1.0149**

Uninsured Pent-Up Demand – 2.08%

As previously uninsured individuals obtain insurance in 2014 and 2015, Anthem expects them to have some pent-up demand for health care services. Based on an internal study of experience by duration for previously uninsured members, we estimate this impact to be 6.1%. We expect that 15% of the Uninsured moving into the Individual market will move in 2014 and the remaining 85% will enter the Individual market in 2015. The 6.1% adjustment is weighted against the portion of the 2015 Individual block that we expect to come from Uninsured to develop a single Pent-Up Demand Load of 1.0208 for 2015.

Exclude Grandfathered from Individual – 3.25%

The base period experience includes both Grandfathered (GF) and Non-Grandfathered (NGF) members. While we anticipate a portion of those GF members moving into the NGF block by 2015, we expect those most likely to make this switch will be the GF members that would get a rate increase by staying in their GF product. After modeling which GF members this would likely include, we looked at their health status (based on risk scores) to estimate the relative morbidity between the expected NGF block in 2015 compared to the total (GF + NGF) block. For IN Individual, the NGF health status (1.2349) compared to the total block health status (1.1960) resulted in a 1.0325 adjustment to account for the different morbidity between Grandfathered and Non-Grandfathered members to derive a Non-Grandfathered only rate.

10) *In Exhibit D, you use a trend of 11.3%, do you have a trend study that helps validate this?*

The pricing trend used in the development of the rates was 11.3%. Our normalized claims trend during this rating period is 8.9%. The assumption used for the impact of the volatility provision is 2.4%.

The normalized claims trend is developed by an actuarial normalization process. The process normalizes historical net benefit expense for changes in the underlying population and known cost

drivers such as age/gender, provider contracting, and benefits. The resulting normalized claims trend is projected forward from the experience period to the rating period. Cost drivers not already included elsewhere in the rate development (e.g., provider contracting) are then combined with the normalized trend to calculate the pricing trend.

11) *For the Medicaid spend down, you have a factor of 1.088. Do you have any documentation that shows how this was determined?*

Please see "Medicaid Spend Down.pdf" included with this response that provides the necessary documentation in support of the Medicaid Spend Down adjustment of 1.088.

12) *In Exhibit E, you have a PMPM of -5.97 for the Rx Rebates. How does this tie back to the supplemental health care exhibit?*

The Rx Rebates in the 2013 Supplemental Health Care Exhibit were -$3.47 for our Individual block of business. The estimate for the Rx Rebates in the 2015 Individual ACA rate filing is -$5.97. Please note, the Supplemental Health Care Exhibit is on a Statutory basis, whereas the estimate in the rate filing is on a GAAP basis.

The 2015 Rx Rebates were derived using 2015 projected membership, expected scripts, and expected rebate/script to calculate the expected Rx rebate PMPM. The script/1000 utilization assumptions for 2015 were developed by taking the scripts/1000 in 2014 divided by the scripts/1000 in 2013 and assuming the same proportional increase for 2015. Although Rx rebates historically vary between Individual and Small Group, the assumption made was they be the same for 2015 pricing purposes (as was assumed in the 2014 pricing). This is consistent with the expectation that the 2015 Individual market will more closely resemble the Rx utilization & cost patterns seen in today's Small Group market. An adjustment is then applied to the final PMPM on plans where the narrow formulary is being implemented (since the narrow formulary would impact the mix of drugs expected and therefore the magnitude of rebates). To estimate the rebate reduction for the narrow formulary, it is assumed that any drug moving to a less favorable position (a higher tier or becoming non-covered) will not receive any rebates, and any drug remaining in its current position will retain the same level of rebate. The 2015 adjustment factors for the narrow formulary are consistent with the adjustment factors used in 2014, since as of now, we are unsure of any changes that will be made to the formularies from 2014.

13) *Please provide some detail around the dental and vision PMPM that are used.*

Pediatric Dental – $0.58 PMPM

Please see "Pediatric Dental.pdf" included with this response that provides an example of the Pediatric Dental pricing that can be applied to each benefit plan.

The average Pediatric Dental claim cost of $0.58 PMPM in Exhibit E is then calculated as a member-weighted average of the claim cost of each benefit plan, using the projected membership distribution assumptions in our pricing model.

Pediatric Vision – $0.72 PMPM

Costs for pediatric vision were estimated using company specific claim costs and utilization rates. Pediatric vision is embedded into all of our plans for 2015. Our estimated claims cost PMPM was $4.51 which was then adjusted by an estimated child population of 16%. Pediatric vision claims cost of $0.72 ($4.51 x 16%) PMPM was added to all plans.

Please see "Pediatric Vision Cost & Utilization IND.pdf" included with this response that provides further detail.

14) *You have a reinsurance PMPM of 34.30. How was this determined?*

The reinsurance PMPM of $34.30 was determined by using a 2012 Milliman CPD table that is calibrated to the actual allowed dollars in the rate development for the Individual block. Further, an assumed average plan design is applied to the allowed table, getting back to a paid basis. The paid basis is then calibrated to the actual paid dollars in the rate development for the Individual block. Lastly, the HHS Reinsurance parameters are applied to those paid dollars to calculate the expected Reinsurance payment for the block.

Please see "Reinsurance.pdf" included with this response that provides further detail.

15) *In Exhibit G, please provide any additional breakouts of the administrative cost.*

The approximate breakouts of the administrative cost are as follows:

Marketing:	$3.94
Sales:	$4.11
Claims Processing:	$1.04
Enrollment & Billing:	$2.17
Other Operational Expenses:	$2.96
Other Expenses, including Overhead and IT:	$13.32
Total	$27.55

16) *In Exhibit G, please compare the Quality Improvement expense to the last two years of supplemental health care exhibit results.*

The Quality Improvement expense in the Supplemental Health Care Exhibit was $2.69 in 2012 and $2.95 in 2013. The estimate for the Quality Improvement expense in the 2015 Individual ACA rate filing is $3.98. The estimate in the 2014 Individual ACA rate filing was $2.94.

The increase from 2014 ACA to 2015 ACA is related to a new area established internally called Commercial Risk Management. As a result of ACA, this area was created to work with an outside vendor that assists us in analyzing Risk Adjusters, Reinsurance and Risk Corridors.

Please note, the Supplemental Health Care Exhibit is on a Statutory basis, whereas the estimate in the rate filing is on a GAAP basis.

17) *How was the ACA insurer fee determined and how does this compare to last years filing?*

The 2014 Individual ACA rate filing included an ACA Insurer fee of 2.68% compared to the 3.79% fee in the 2015 filing.

The total fee amount to be collected across all health insurers is set at $8 billion in 2014 and $11.3 billion in 2015. This results in a non-grossed up fee of 1.6% in 2014 and 2.26% in 2015. However, the fee is not tax deductible, so in order to break even it needs to be grossed up for taxes. Assuming a Federal tax rate of 35% and a State Income tax rate of 8.25%, the derivation of the 2015 ACA Insurer fee is as follows:

$2.26\% * [1 / (1 – (0.35 + 0.0825 * (1 – 0.35)))] = 3.79\%$

18) *Please provide some detail on how the calibration was done for Tobacco and Age in Exhibit H?*

The rating factors used for age and tobacco are shown in Exhibit J of the Actuarial Memorandum.

The average age rating factor shown in Exhibit H is calculated as a member-weighted average of the age rating factors, using the projected age distribution assumptions in our pricing model, with an adjustment for the maximum of 3 child dependents under age 21.

The average tobacco rating factor is calculated using the projected distribution of members by age and tobacco status as follows:

(Number of tobacco users x Weighted average of combined age and tobacco factors for tobacco users + Number of non-tobacco users x Weighted average age factor for non-tobacco users) / (Total number of members x Weighted average age factor for all members)

These member-weighted averages also include an adjustment for the maximum of 3 child dependents under age 21, as mentioned above.

The average tobacco rating factor is used in the calculation of the base rate shown in Exhibit A of the Actuarial Memorandum, but per the memorandum instructions, the average tobacco rating factor is not included as a calibration factor in Exhibits H and O.

19) When would the Out of Area rating factor be used?

As part of our area factor development, an Out of Area factor was calculated, but no projected membership was applied to it. Hence, it does not impact the rate and no one could actually receive an Out of Area rate. For clarity, we removed the Out of Area factor in Exhibit K of our revised Actuarial Memorandum submitted to compliance@idoi.in.gov on 6/5/14.

20) Can you tie the premiums in Exhibit L back to those in Exhibit O?

Exhibit O can be tied back to Exhibit L by developing the base rate in Exhibit L from the Market Adjusted Index Rate in Exhibit O. Please see "IN IND Index to Base dev.pdf" included with this response that provides that development.

21) How many distinct provider contracts are used in Exhibit O?

Anthem has 3,971 professional contracts and 131 facility contracts.

22) If you have not submitted a print out of the AV calculations of each plan, please do so.

Anthem has submitted the AV screen shots to the IDOI with our initial submission of the rate filing. However, for your convenience, I have included them with this response ("IND ON AV Screen Shots.pdf" and "IND OFF AV Screen Shots.pdf").

Formulary Drug Tier Movement

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
1ST TIER UNIFINE PENTIPS	2	3
ABACAVIR	1	4
ABILIFY	2	3
ACAMPROSATE CALCIUM	1	2
ACCU-CHEK	3	2
ACCU-CHEK COMPACT	2	3
ACCU-CHEK IIM MONITOR	2	3
ACCUTREND GLUCOSE	3	2
ACE AEROSOL CLOUD ENHANCER	2	3
ACETEST REAGENT	2	3
ACETYLCYSTEINE	1	2
ACITRETIN	1	2
ACTONEL	2	3
ACURA METER KIT	2	3
ACURA STARTER KIT	2	3
ADVOCATE PEN NEEDLES	2	3
ADVOCATE SYRINGES	2	3
AEROCHAMBER	2	3
AEROCHAMBER PLUS	2	3
AEROCHAMBER Z-STAT PLUS	2	3
AEROTRACH PLUS	2	3
AFINITOR	2	4
AFINITOR DISPERZ	3	4
AIMSCO MINI ULTRA-THIN II	2	3
AIMSCO ULTRA THIN II	2	3
AIR FILTER	2	3
ALCOHOL PREP PAD	2	3
ALCOHOL WIPES	2	3
ALKERAN	2	4
ALTABAX	2	3
AMIFOSTINE	1	4
AMIKACIN SULFATE	1	2
AMITIZA	2	3
AMPHOTERICIN B	1	2
AMPICILLIN SODIUM	1	2
AMPICILLIN/SULBACTAM	1	2
ANAGRELIDE HYDROCHLORIDE	1	4
ANASPAZ	1	2
ANASTROZOLE	1	4
ANDROGEL	2	3
APRISO	2	3
APTIVUS	2	4
ARZERRA	3	4

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
ASSURE ID INSULIN SAFETY	2	3
ASTHMAPACK CHILDREN'S	2	3
ASTHMAPACK I	2	3
ASTHMAPACK II	2	3
ATRIPLA	2	4
ATROPINE SULFATE	1	2
AUTOJECT 2	2	3
AUTOLET PLATFORMS	2	3
AUTOPEN	2	3
AVODART	2	3
AZATHIOPRINE	1	4
AZILECT	2	3
AZOPT	2	3
AZTREONAM	1	2
BABY CONVERSION KIT	2	3
BABY NEBULIZER	2	3
B-D AUTO INJECTOR	2	3
BD AUTOSHIELD PEN NEEDLE	2	3
BD ECLIPSE	2	3
BD INSULIN PEN NEEDLE UF MINI	2	3
B-D INSULIN SYRINGE	2	3
BD INSULIN SYRINGE MF	2	3
BD INTEGRA SYRINGE	2	3
BD INTERLINK SYRINGE	2	3
BD NANO PEN NEEDLE	2	3
B-D SAFE CLIP	2	3
B-D SAFETYGLIDE	2	3
B-D SAFETYGLIDE ALLERGY	2	3
BD SAFETYGLIDESYRINGE	2	3
BD SYRINGE	2	3
BENZOTIC	1	3
BENZOYL PEROXIDE	1	3
BETHANECHOL CHLORIDE	1	2
BICALUTAMIDE	1	4
BLOOD PRESSURE CUFF	2	3
BLOOD PRESSURE KIT	2	3
BLOOD PRESSURE MONITOR	2	3
BOSULIF	2	4
BP WASH	3	1
BREATHERITE	2	3
BRILINTA	2	3
BROMFENAC SODIUM	1	2
BUDESONIDE EC	1	2
BUFFERIN	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
BULK SYRINGE	2	3
BUPRENORPHINE HYDROCHLORIDE	1	2
BUSULFEX	3	4
BYDUREON	2	3
CALCITONIN-SALMON	1	2
CALCIUM ACETATE	1	2
CAPRELSA	2	4
CAREONE	2	3
CARTRIDGE STAMPED	2	3
CEENU	2	4
CEFAZOLIN SODIUM	1	2
CEFEPIME HCL	1	2
CEFEPIME-DEXTROSE	3	2
CEFOTAXIME SODIUM	1	2
CEFOTETAN	1	2
CEFOTETAN & DEXTROSE	3	2
CEFOXITIN	1	2
CEFPODOXIME PROXETIL	1	2
CEFTAZIDIME	1	2
CEFTRIAXONE	1	2
CELLCEPT	3	4
CEVIMELINE HCL	1	2
CHEK-STIX	2	3
CHEMSTRIP	2	3
CHEMSTRIP 10 WITH SG	2	3
CHEMSTRIP 2 GP	2	3
CHEMSTRIP 50B	2	3
CHEMSTRIP 7	2	3
CHEMSTRIP 9	2	3
CHEMSTRIP K	2	3
CHEMSTRIP UGK	2	3
CHILDREN'S MOTRIN	2	3
CHLORAMPHENICOL SOD SUCCINATE	1	2
CIDOFOVIR	1	2
CILOSTAZOL	1	2
CIPRODEX	2	3
CIPROFLOXACIN	1	2
CIPROFLOXACIN-D5W	1	2
CLICKFINE	2	3
CLINISTIX REAGENT	2	3
CLINITEST REAGENT	2	3
CLOZAPINE	1	2
CLOZAPINE ODT	1	2
COLCRYS	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
COMBIGAN	2	3
COMBISTIX REAGENT	2	3
COMETRIQ	3	4
COMFORT EZ	2	3
COMFORT LANCETS	2	3
COMMIT	2	3
COMP-AIR ELITE COMPRESSOR SYST	2	3
CONCEPTROL	2	3
CRESTOR	2	3
CRIXIVAN	2	4
CUPRIMINE	2	3
CURITY ALCOHOL PREPS	2	3
CYCLOPHOSPHAMIDE	1	4
CYCLOSPORINE	1	4
CYMBALTA	2	3
DANAZOL	1	2
DANTROLENE SODIUM	1	2
DAPSONE	2	3
DARAPRIM	2	3
DAVOL IRRIGATION SYRINGE	2	3
DELUXE ARM BP MONITOR	2	3
DEMECLOCYCLINE HCL	1	2
DESIPRAMINE HCL	1	2
DEVILBISS PULMO-AIDE	2	3
DEVILBISS TRAVELER	2	3
DEX4 GLUCOSE	2	3
DIABETIC.COM STARTER	2	3
DIASCREEN 10	2	3
DIASCREEN 1B REAGENT	2	3
DIASCREEN 1G REAGENT	2	3
DIASCREEN 1K REAGENT	2	3
DIASCREEN 2GK REAGENT	2	3
DIASCREEN 2GP	2	3
DIASCREEN 3 REAGENT	2	3
DIASCREEN 4NL REAGENT	2	3
DIASCREEN 4OBL	2	3
DIASCREEN 4PH	2	3
DIASCREEN 5	2	3
DIASCREEN 6	2	3
DIASCREEN 7	2	3
DIASCREEN 8	2	3
DIASCREEN 9	2	3
DIASTIX REAGENT	2	3
DIBENZYLINE	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
DIDANOSINE	1	4
DIFFERIN	2	3
DIHYDROERGOTAMINE MESYLATE	1	2
DIOVAN	2	3
DIPHENHYDRAMINE HCL	1	2
DIPYRIDAMOLE	1	2
DRONABINOL	1	2
DROXIA	2	4
DUREZOL	2	3
EASIVENT	2	3
EASY CHECK	2	3
EASY COMFORT INSULIN SYRINGE	2	3
EASY COMFORT PEN NEEDLES	2	3
EASY TOUCH	2	3
EASY TOUCH ALCOHOL PREP PADS	2	3
EASY TOUCH FLURINGE	2	3
EASY TOUCH INSULIN SAFETY	2	3
EASY TRAK	2	3
EASYMAX L	2	3
ECLIPSE SYRINGE-NEEDLE	2	3
EDURANT	2	4
EFFIENT	2	3
ELIDEL	2	3
ELIPHOS	1	2
ELSPAR	3	4
EMCYT	2	4
EMTRIVA	2	4
ENFAMIL	2	3
ENTACAPONE	1	2
EPINEPHRINE	1	2
EPLERENONE	1	2
EPZICOM	2	4
ERAPID NEBULIZER	2	3
ERGOLOID MESYLATES	1	2
ERIVEDGE	2	4
ESTRING	2	3
ETIDRONATE DISODIUM	1	2
ETOPOPHOS	3	4
ETOPOSIDE	1	4
EXEL ALLERGY SYRINGE	2	3
EXEL INSULIN SYRINGE	2	3
EXEL SYRINGE	2	3
EXEL TUBERCULIN SYRINGE	2	3
EXEMESTANE	1	4

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
EXPRESS MED STARTER	2	3
EZ SMART PLUS	2	3
E-Z SPACER	2	3
E-Z SPACER PEDSPAK	2	3
FARESTON	2	4
FEMTRACE	2	3
FENTANYL	1	2
FINACEA	2	3
FINACEA PLUS	2	3
FIRMAGON	3	4
FLECAINIDE ACETATE	1	2
FLUDARABINE PHOSPHATE	1	4
FLUOROPLEX	2	3
FLUTAMIDE	1	4
FLUTTER	2	3
FORA D10	3	1
FORA D15	2	3
FORA D15C	3	1
FORA D15Z	3	1
FORA V10	3	1
FORA V12	3	1
FORTICAL	1	2
FOSAMAX	2	3
FOSAMAX PLUS D	2	3
FOSCARNET SODIUM	1	2
FOSPHENYTOIN SODIUM	1	2
FREESTYLE CONTROL SOLUTION	2	3
FREESTYLE PRECISION	2	3
FUZEON	2	4
G-4	2	3
GABAPENTIN	1	2
GALANTAMINE	1	2
GENGRAF	1	4
GILOTRIF	3	4
GLASPAK	2	3
GLEEVEC	2	4
GLUCO SHOT	2	3
GLUCOPRO	2	3
GLUCOSE	2	3
GLUTOL	2	3
GLYSET	2	3
GRANISETRON HCL	1	2
HEALTHY ACCENTS UNIFINE PENTIP	2	3
HEMA-COMBISTIX	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
HEPARIN LOCK FLUSH	1	2
HEPARIN SODIUM	1	2
HEPARIN SODIUM IN 0.45% NACL	1	2
HEPARIN SODIUM IN 0.9% NACL	1	2
HEPARIN SODIUM IN 5% DEXTROSE	1	2
HEP-LOCK	1	2
HEXALEN	2	4
HUMAPEN LUXURA HD	2	3
HUMAPEN MEMOIR	2	3
HYCAMTIN	2	4
HYDROXYUREA	1	4
ICLUSIG	2	4
IMIPENEM-CILASTATIN SODIUM	1	2
IN CONTROL BLOOD MONITOR	2	3
IN CONTROL PEN NEEDLE	2	3
INCONTROL	2	3
INDOMETHACIN	1	2
INLYTA	2	4
INNOSPIRE ELEGANCE	2	3
INNOSPIRE ESSENCE	2	3
INNOVO	2	3
INSPIRATION ELITE	2	3
INSPIRATION NEBULIZER SYSTEM	2	3
INSPIREASE	2	3
INSUL-CAP	2	3
INSUL-EZE	2	3
INSULIN PEN NEEDLE	2	3
INSULIN- SYRINGE	2	3
INSUMED	2	3
INSUPEN	2	3
INTELENCE	2	4
INVIRASE	2	4
IRESSA	2	4
ISENTRESS	2	4
ISOPROPYL ALCOHOL	2	3
ITRACONAZOLE	1	2
IV PREP WIPES	2	3
JAKAFI	2	4
JANUMET	2	3
JANUMET XR	2	3
JANUVIA	2	3
KALETRA	2	4
KANAMYCIN SULFATE	1	2
KETOCARE	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
KETO-DIASTIX REAGENT	2	3
KETONE	2	3
KETOROLAC TROMETHAMINE	1	2
KETOSTIX REAGENT	2	3
KINRAY	2	3
LABSTIX REAGENT STRIPS	2	3
LAMIVUDINE	1	4
LAMIVUDINE-ZIDOVUDINE	1	4
LANCET	2	3
LANCING DEVICE	2	3
LANCING SYSTEM	2	3
LANOXIN	2	3
LC D NEBULIZER SET	2	3
LC PLUS	2	3
LC SPRINT NEBULIZER	2	3
LEFLUNOMIDE	1	2
LETROZOLE	1	4
LEUCOVORIN CALCIUM	1	4
LEUKERAN	2	4
LEUPROLIDE ACETATE	1	4
LEVALBUTEROL HCL	1	2
LEVETIRACETAM	1	2
LEVOCARNITINE	1	2
LEVOMEFOLATE DHA	3	1
LEVOMEFOLATEPNV	3	1
LEVORPHANOL TARTRATE	1	2
LEXIVA	2	4
LIFE MEDICAL STARTER	2	3
LIFESHIELD BLUNT CANNULA	2	3
LITE TOUCH	2	3
LITEAIRE	2	3
LITETOUCH	2	3
LOESTRIN 24 FE	2	3
LOMUSTINE	3	4
LONG STARTER	2	3
LOTEMAX	2	3
LOVAZA	2	3
LUER LOCK SYRINGE	2	3
LUER-LOK SYRINGE	2	3
LUER-LOK SYRINGE-NEEDLE	2	3
LUER-LOK TIP SYRINGE	2	3
LUFYLLIN	2	3
LUMIGAN	2	3
LYSODREN	2	4

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
MAFENIDE ACETATE	1	2
MAGELLAN INSULIN SAFETY SYRNG	2	3
MAGELLAN INSULIN SYRINGE	2	3
MAGNESIUM SULFATE	1	2
MATULANE	2	4
MAXI-COMFORT	2	3
MEDI-JECTOR VISION	2	3
MEDSAVER	2	3
MEDTRONIC REMOTE CONTROL	2	3
MEKINIST	3	4
MELPHALAN HCL	1	4
MENEST	2	3
MEPRON	2	3
MERCAPTOPURINE	1	4
MEROPENEM	1	2
METHENAMINE HIPPURATE	1	2
METHOTREXATE	1	4
METHOTREXATE SODIUM	1	4
METHYLDOPATE HCL	1	2
MEXILETINE HCL	1	2
MICRO ELITE	2	3
MICROCHAMBER	2	3
MICRODOT	2	3
MICROSPACER	2	3
MINI ULTRA-THIN II	2	3
MINIELITE	2	3
MINIMED	2	3
MITOXANTRONE	1	4
MONOJECT	2	3
MONOJECT INSULIN SYRINGE	2	3
MONOJECT PHARMACY TRAY	2	3
MONOJECT PREFILL	1	2
MONOJECT PREFILL ADVANCED	1	2
MONOJECT SYRINGE	2	3
MONOJECTOR LANCET DEVICE	2	3
MONOLET THIN LANCETS	2	3
MORPHINE SULFATE	1	2
MORPHINE SULFATE ER	1	2
MOTRIN	2	3
MULTISTIX	2	3
MULTISTIX 10 SG	2	3
MULTISTIX 5	2	3
MULTISTIX 7	2	3
MULTISTIX 8 SG	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
MULTISTIX 9	2	3
MULTISTIX 9 SG	2	3
MYCOBUTIN	2	3
MYCOPHENOLATE MOFETIL	1	4
MYFORTIC	3	4
MYGLUCOHEALTH CONTROL SOLUTION	2	3
MYLERAN	2	4
NAFCILL IN DEXTROSE	1	2
NAFCILLIN SODIUM	1	2
NALBUPHINE HCL	1	2
NALOXONE HCL	1	2
NAMENDA	2	3
NATAFORT	3	1
NATEGLINIDE	1	2
NAVARRO STARTER	2	3
NEEDLES	2	3
NEVIRAPINE	1	4
NEWTEK	2	3
NEXAVAR	2	4
NEXIUM	2	3
NIASPAN	2	3
NILANDRON	2	4
NIMODIPINE	1	2
NITROGLYCERIN	1	2
NORVIR	2	4
NOVOFINE	2	3
NOVOFINE AUTOCOVER	2	3
NOVOLIN 70-30	3	2
NOVOLIN N	3	2
NOVOLIN R	3	2
NOVOPEN 3	2	3
NOVOPEN JR	2	3
NOVOTWIST	2	3
NULOJIX	3	4
NUVARING	2	3
NYSTATIN	3	1
OFORTA	2	4
OLANZAPINE	1	2
OLANZAPINE ODT	1	2
OMNIPOD	2	3
OMONTYS	3	4
ONDANSETRON HCL	1	2
ONDANSETRON ODT	1	2
ONE TOUCH GLUCOSE CONTROL SOLN	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
OPTICHAMBER	2	3
OPTICHAMBER DIAMOND	2	3
OPTIHALER	2	3
OPTIONHOME	2	3
ORSINI INSULIN SYRINGE	2	3
ORTHO EVRA	2	3
ORTHO TRI-CYCLEN LO	2	3
OTIC CARE	3	1
OXACILLIN SODIUM	1	2
OXANDROLONE	1	2
OXYCONTIN	2	3
PANTOPRAZOLE SODIUM	1	2
PARADIGM REMOTE CONTROL	2	3
PARI LC PLUS NEBULIZER	2	3
PARICALCITOL	1	2
PEN- NEEDLE	2	3
PENICILLIN G POTASSIUM	1	2
PERFOROMIST	2	3
PFIZERPEN	1	2
PFLEX TRAINER	2	3
PILOCARPINE HCL	1	2
PIPERACILLIN	1	2
POCKET CHAMBER	2	3
POLY IRON PN FORTE	3	1
POLYMYXIN B SULFATE	1	2
POMALYST	3	4
POTASSIUM CHL-NORMAL SALINE	1	2
POTASSIUM CHLORIDE	1	2
PRADAXA	2	3
PRECISION	2	3
PRECISIONGLIDE	2	3
PREMARIN	2	3
PREMIUM ARM BP MONITOR	2	3
PREMPHASE	2	3
PREMPRO	2	3
PRENATAL 19	3	1
PREZISTA	2	4
PREZISTA	3	4
PRIFTIN	2	3
PRIMAQUINE	2	3
PRIMEAIRE	2	3
PRISTIQ ER	2	3
PROCAINAMIDE HCL	1	2
PROCHAMBER	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
PRODIGY INSULIN SYRINGE	2	3
PRODIGY MINI-MIST	2	3
PRODIGY PEN NEEDLE	2	3
PRODIGY POCKET	2	3
PRONEB ULTRA II	2	3
PROPAFENONE HCL	1	2
PROTOPIC	2	3
PRUDOXIN	1	2
PULMO-AIDE COMPRESSOR	2	3
QUICK RESPONSE	2	3
RANEXA	2	3
RAPAMUNE	2	4
REFUAH PLUS	2	3
RELION PEN NEEDLES	2	3
RELION VENTOLIN HFA	2	3
RENVELA	2	3
REPAGLINIDE	1	2
RESCRIPTOR	2	4
RESTASIS	2	3
REUSABLE NEBULIZER KIT	2	3
REVLIMID	2	4
REYATAZ	2	4
RIDAURA	2	3
RIFATER	2	3
RIGHTEST GM300 SYSTEM	2	3
RITEFLO	2	3
RITUXAN	3	4
RIVASTIGMINE	1	2
ROCK CANDY	2	3
SAFESNAP ALLERGY SYRINGE	2	3
SAFESNAP INSULIN SYRINGE	2	3
SAFESNAP SYRINGE	2	3
SAFESNAP TUBERCULIN SYRINGE	2	3
SAFETY SYRINGE WITH SHIELD	2	3
SAFETY-LOK SAFETY SYRINGE	2	3
SAFETY-LOK SYRINGES	2	3
SAMI THE SEAL	2	3
SAMI THE SEAL MASK	2	3
SAVELLA	2	3
SELF-TAKING BLOOD PRESSURE	2	3
SELZENTRY	2	4
SEROQUEL XR	2	3
SIDESTREAM	2	3
SIDESTREAM MASK	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
SIL-SERTER	2	3
SIMULECT	3	4
SINGLE USE SWAB	2	3
SINGLE-LET	2	3
SMARTEST EJECT	2	3
SMARTEST PROTEGE	2	3
SODIUM CHLORIDE	1	2
SODIUM SULFACETAMIDE/SULFUR	3	1
SOF-SERTER	2	3
SORINE	1	2
SOTALOL	1	2
SOTALOL AF	1	2
SPIRIVA	2	3
SPRYCEL	2	4
STAVUDINE	1	4
STIVARGA	2	4
STRATTERA	2	3
SULFADIAZINE	1	2
SUMATRIPTAN SUCCINATE	1	2
SUNRISE COMPRESSOR-NEBULIZER	1	3
SUPER THIN LANCETS	2	3
SURE COMFORT	2	3
SURE COMFORT ALCOHOL PREP PADS	2	3
SURE-FINE PEN NEEDLES	2	3
SURE-JECT INSULIN SYRINGE	2	3
SURE-PREP ALCOHOL PREP PADS	2	3
SURE-TEST EASYPLUS MINI	2	3
SUSTIVA	2	4
SUTENT	2	4
SYMLINPEN 120	2	3
SYMLINPEN 60	2	3
SYNRIBO	3	4
SYRINGE	2	3
SYRINGE BULK	2	3
SYRINGE W/SAFETY GLIDE	2	3
SYRINGE WITH NEEDLE DISP	2	3
SYRINGE WITHOUT NEEDLE	2	3
SYRINGE-DUAL CANNULA	2	3
SYRINGE-PRECISIONGLIDE NEEDLE	2	3
TABLOID	2	4
TACROLIMUS	1	4
TAFINLAR	3	4
TAMOXIFEN CITRATE	1	4
TARCEVA	2	4

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
TARGRETIN	2	4
TASIGNA	2	4
TAZORAC	2	3
TEAR AGAIN HYDRATE	2	3
TEARS AGAIN	2	3
TEMODAR	3	4
TEMOZOLOMIDE	1	4
TERUMO HYPODERMIC NEEDLE-SYRIN	2	3
TERUMO INSULIN SYRINGE	2	3
TERUMO SYRINGE	2	3
THALOMID	2	4
THINPRO INSULIN SYRINGE	2	3
TIAGABINE HCL	1	2
TIS-U-SOL	1	2
TOBRADEX	2	3
TOPCARE ULTRA COMFORT	2	3
TOPOTECAN HCL	1	4
TORISEL	2	4
TOVIAZ	2	3
TRADJENTA	2	3
TRANEXAMIC ACID	1	2
TRANSDERM-SCOP	2	3
TRAVATAN Z	2	3
TREK S COMBO PACK	2	3
TREK S COMPACT COMPRESSOR	2	3
TRELSTAR	3	4
TRELSTAR DEPOT	3	4
TRELSTAR LA	3	4
TRETINOIN	1	4
TRIZIVIR	2	4
TROSPIUM CHLORIDE	1	2
TRUEPLUS INSULIN SYRINGE	2	3
TRUETEST TEST STRIPS	3	1
TRUETRACK SMART SYSTEM	3	1
TRUVADA	2	4
TRUZONE PEAK FLOW METER	2	3
TYKERB	2	4
ULTICARE	2	3
ULTICARE INSULIN SYRINGE	2	3
ULTILET	2	3
ULTILET ALCOHOL SWAB	2	3
ULTILET INSULIN SYRINGE	2	3
ULTILET PEN NEEDLE	2	3
ULTIMA	3	1

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
ULTRA COMFORT	2	3
ULTRA-THIN II	2	3
ULTRATLC LANCETS	2	3
ULTRATRAK PRO	3	1
ULTRATRAK ULTIMATE	2	3
UNIFINE PENTIPS	2	3
UNIFINE PENTIPS PLUS	2	3
URISTIX 4	2	3
URISTIX REAGENT	2	3
URSODIOL	1	2
VAGIFEM	2	3
VANCOMYCIN HCL	1	2
VANDETANIB	2	4
VANISHPOINT	2	3
VCF	2	3
VENLAFAXINE HCL ER BRAND	3	1
VENTOLIN HFA	2	3
VESICARE	2	3
VGO 20	2	3
VGO 30	2	3
VGO 40	2	3
VICTOZA	2	3
VIGAMOX	2	3
VIOS AEROSOL DELIVERY SYSTEM	2	3
VIRACEPT	2	4
VIREAD	2	4
VIVELLE- DOT	2	3
VOCALPOINT GLUCOSE CONTROL	2	3
VOLTAREN	2	3
VORICONAZOLE	1	2
VORTEX	2	3
VORTEX VHC FROG MASK	2	3
VORTEX VHC LADYBUG MASK	2	3
VOTRIENT	2	4
VYVANSE	2	3
WATCHHALER	2	3
WAVESENSE AMP	2	3
W-D STARTER	2	3
WEBCOL ALCOHOL PREPS	2	3
WELCHOL	2	3
WOMEN'S ADVANCED BP MONITOR	2	3
WOUND WASH SALINE	1	2
XALKORI	2	4
XARELTO	2	3

Trade Name	Open Formulary Tier	IN Closed Formulary Tier
XELODA	2	4
XTANDI	2	4
YALE SYRINGE	2	3
YERVOY	3	4
ZANOSAR	3	4
ZELBORAF	2	4
ZIDOVUDINE	1	4
ZOLEDRONIC ACID	1	4
ZOLINZA	2	4
ZONISAMIDE	1	2
ZYTIGA	2	4

Indiana Individual Early Renewal (Transition Policy) Load

Expected Relative Morbidity in Individual Block

	Morbidity	ACA Market Share	
Anthem	0.8321	75.0%	(1)
Others	1.0000	25.0%	(2)
Total Market	0.8741	100.0%	

Anthem Relative Risk to Market	-4.8%	
% of Risk Difference Paid Through RA	66.7%	(3)
Expected Risk Adjustment Payout	3.2%	

Notes

(1) Anthem morbidity expected to be lower than average competitor, since Anthem not offering transition policies.
Expected ACA Market Share based on all 2015 Anthem membership on ACA, vs. some competitors business on transition policies.

(2) Relative morbidity for competitors set to 1.00.

(3) Assumed 2/3rds of risk difference will be paid through risk adjustment.
Additional 1/3rd estimated due to age differences, caused by transition policies.
(Risk adjustment accounts for differnces in risk, but excludes the portion captured by age rating factors).

IN Individual Wakely Adjustment

Step 1 - Use Small Group Wakely to Normalize Small Group Experience to Market

Participation		
# carriers	6	
Participating Market Share	83%	
Anthem Market Share	55%	
Anthem Relative Risk for 2013		
Carrier	Market Share	Relative Risk*
Anthem	55.0%	1.01305
Market	83.0%	1.0000

* Relative Risk is based on HHS risk adjustment methodology, which normalizes for allowable rating factors.

Step 2 - Apply Individual Market Premium Adjustment

Anthem Premium vs. Market Leaders	0%
Adjustment from Anthem to Market Premium*	1.00
Anthem Relative Risk (expected transfers)	0.0131
Expected Transfers at Market Premium	0.0131

* Risk adjustment is based on market premium. Anthem estimates market premium to be similar to market.

Final Experience to Rating Period Adjustment	**0.9869**

Medicaid Spend Down
2015 Impact
2013 Incurred Claims Paid thru Mar-14
Source: IDOI

	Member Months	Medicaid Allowed	Commercial Allowed	Commercial Paid	Paid PMPM
2013	73,867	139,695,386	200,588,051	137,477,246	1,861.15
2015	40,196			84,056,533	2,091.18

Assumptions	
Network Discount:	47.0%
Trend:	6.0%
Spend Down Mbrs:	6,836
Market Share:	49.0%
Paid to Allowed Ratio:	0.6854

ACA Block

Member Months:	1,556,200
Claims PMPM:	399.63
Claims	621,904,396

Spend Downers

Member Months:	40,196
Claims PMPM:	2091.18
Claims	84,056,533
Reinsurance	11,761,987
Total Claims Impact	72,294,546

ACA Block with Spend Downers

Member Months:	1,596,396	
Claims PMPM:	434.85	8.8%
Claims	694,198,942	

Medicaid Spend Down
2015 Impact of Reinsurance

2015 Projected					
Claims	Unique Members		Claims		Avg
Per Member	Count	Percent	Amount	Percent	Claim/Mem.
$0	1,297	11.78%	$0	0.00%	$0
$1 to 70000	8,837	80.28%	$95,353,255	42.31%	$10,790
$70001 to 250000	782	7.10%	$94,225,742	41.81%	$120,493
>$250001	92	0.84%	$35,801,738	15.89%	$389,149
Total	11,008	100.00%	$225,380,735	100.00%	$20,474

Reinsurance $28,022,871
50% in excess of 70K
capped at 250K

Adjusted for Revised Membership Assumption

2015 Projected					
Claims	Unique Members		Claims		Avg
Per Member	Count	Percent	Amount	Percent	Claim/Mem.
$0	395	11.78%	$0	0.00%	$0
$1 to 70000	2,689	80.28%	$35,562,330	42.31%	$13,225
$70001 to 250000	238	7.10%	$35,141,820	41.81%	$147,682
>$250001	28	0.84%	$13,352,383	15.89%	$476,959
Total	3,350	100.00%	$84,056,533	100.00%	$25,094

Reinsurance $11,761,987
50% in excess of 70K
capped at 250K

Indiana Embedded Dental Pricing Detail

The embedded pediatric dental pricing for 2015 was developed using the 2014 stand alone Anthem Dental Pediatric product which mimic the benefits of the embedded pediatric dental pricing in terms of coinsurance and benefits covered.

2014 Claim Cost	$13.63

Claim Cost Adjustments

A 3% claim cost trend is used to trend the 2014 claim costs to 2015

Trend	1.03

All members have the benefit embedded into their medical plan, but only pediatric members have a benefit. Costs are spread over all members.

Expected % of Pediatric Membership	14.44%

The embedded pediatric dental benefits apply to the medical deductible. The appropriate factor from the Deductible Factor Exhibit is used based on the In Network medical deductible.

Deductible Factor	*See Deductible Factor Exhibit

Final Claim Cost

Final Claim Cost	**=$13.63 * 1.03 * .1444 * Deductible Factor**

Indiana Embedded Dental Pricing Detail

Deductible Factor Exhibit

Medical Deductible	Factor
$0	1.000
$150	0.929
$175	0.901
$200	0.887
$250	0.858
$300	0.830
$350	0.802
$475	0.736
$500	0.723
$600	0.683
$700	0.644
$725	0.634
$750	0.624
$800	0.609
$850	0.594
$1,000	0.549
$1,100	0.528
$1,150	0.517
$1,200	0.507
$1,250	0.496
$1,300	0.486
$1,450	0.454
$1,500	0.443
$1,600	0.429
$1,700	0.415
$1,750	0.408
$1,800	0.401
$1,850	0.394
$2,000	0.373
$2,100	0.363
$2,150	0.358
$2,200	0.353
$2,250	0.348
$2,350	0.337
$2,400	0.332
$2,450	0.327
$2,500	0.322
$2,600	0.315
$2,750	0.304
$2,800	0.300
$2,850	0.296
$2,900	0.293
$3,000	0.285
$3,200	0.275
$3,250	0.272
$3,350	0.267
$3,500	0.259
$3,600	0.253
$3,750	0.245
$3,800	0.243
$3,850	0.240
$4,000	0.232
$4,200	0.224
$4,300	0.221
$4,350	0.219
$4,400	0.217
$4,500	0.213
$5,000	0.195
$5,250	0.189
$5,500	0.184
$5,550	0.182
$5,600	0.181
$5,700	0.179
$5,750	0.178
$5,800	0.177
$5,850	0.176
$5,900	0.174
$5,950	0.173
$6,000	0.172
$6,050	0.171
$6,100	0.170
$6,150	0.169
$6,200	0.168
$6,250	0.166
$6,300	0.165
$6,350	0.164
$6,400	0.163
$6,500	0.161
$6,600	0.158

IN Vision Costs & Utilization

Individual (Pediatric Full Benefit EHB)

Provision	Frequency	Copay	Allowance	Cost	Utilization/Member	Cost X Util/12
Routine Eye Exam	Once every calendar year	$0	N/A	$ 51.92	27.50%	1.19
Lenses (SV, BV, TV, Progressive)	Once every calendar year	$0	N/A	$ 60.30	19.25%	0.97
Frames	Once every calendar year	$0	Formulary ($150 approx)	$ 82.50	19.25%	1.32
Contact Lenses	Once every calendar year	$0	Formulary ($150 approx)	$ 150.00	8.25%	1.03
						$ 4.51

	Claim Cost	Member%	CC * Member%
Pediatric	$ 4.51	16%	$ 0.72

Reinsurance INPUTS

National Contribution Rate PMPM	3.67	HHS
Attachment Point	70K	HHS
Coinsurance	50%	HHS
Reinsurance Cap	250K	HHS
Allowed PMPM (Index Rate)	$ 627.63	Exhibit N
Paid PMPM	$ 430.18	Exhibit N
Payments PMPM before Adjustment	$ 34.30	
Scale Back Factor	1.000	based on national analysis
Payments PMPM after Adjustment	$34.30	

Assumed "Average" Exchange Plan Design

Deductible:	1500
OOPM:	4500
Coinsurance:	20%

Billed (2013) CPD Source

Milliman, Inc.
2012 Health Cost Guidelines
Commercial Claim Probability Distributions
MEMBER * ADULT *** CHILD**

TYPE OF COVERAGE: TABLE 1A - ALL COVERAGES
INSURED TYPE: MEMBER
CLAIM CENTER DATE: 7/1/2012

Base CPDs		Individual			
	Billed (2013)	Alwd (Calibrated to CPD) 2015	Paid (Calibrated to CPD) 2015	Paid	ReinsPmt
Annual Frequency	Annual Claim	Annual Claim	Annual Claim	Annual Claim	Annual Claim
0.0669561	$ -	$ -	$ -	$ -	$ -
0.0225000	$ 28	$ 23	$ -	$ -	$ -
0.0201695	$ 90	$ 75	$ -	$ -	$ -
0.0248991	$ 148	$ 123	$ -	$ -	$ -
0.0249370	$ 208	$ 172	$ -	$ -	$ -
0.0233366	$ 266	$ 221	$ -	$ -	$ -
0.0209388	$ 326	$ 271	$ -	$ -	$ -
0.0193612	$ 385	$ 320	$ -	$ -	$ -
0.0181644	$ 444	$ 369	$ -	$ -	$ -
0.0170821	$ 503	$ 418	$ -	$ -	$ -
0.0163264	$ 559	$ 464	$ -	$ -	$ -
0.0303855	$ 646	$ 537	$ -	$ -	$ -
0.0276391	$ 764	$ 634	$ -	$ -	$ -
0.0252059	$ 881	$ 732	$ -	$ -	$ -
0.0231229	$ 998	$ 829	$ -	$ -	$ -
0.0211851	$ 1,107	$ 919	$ -	$ -	$ -
0.0196992	$ 1,223	$ 1,016	$ -	$ -	$ -
0.0182145	$ 1,339	$ 1,112	$ -	$ -	$ -
0.0170027	$ 1,456	$ 1,209	$ -	$ -	$ -
0.0157445	$ 1,572	$ 1,305	$ -	$ -	$ -
0.0148975	$ 1,689	$ 1,402	$ -	$ -	$ -
0.0140647	$ 1,804	$ 1,498	$ -	$ -	$ -
0.0132606	$ 1,920	$ 1,595	$ 76	$ 66	$ -
0.0124883	$ 2,037	$ 1,691	$ 153	$ 133	$ -
0.0118619	$ 2,150	$ 1,785	$ 228	$ 199	$ -
0.0112120	$ 2,266	$ 1,882	$ 305	$ 266	$ -
0.0255892	$ 2,469	$ 2,050	$ 440	$ 384	$ -
0.0227160	$ 2,760	$ 2,292	$ 633	$ 552	$ -
0.0202469	$ 3,049	$ 2,532	$ 826	$ 719	$ -
0.0182695	$ 3,340	$ 2,773	$ 1,019	$ 887	$ -
0.0164585	$ 3,630	$ 3,014	$ 1,211	$ 1,055	$ -
0.0150369	$ 3,925	$ 3,259	$ 1,407	$ 1,226	$ -
0.0137100	$ 4,215	$ 3,500	$ 1,600	$ 1,393	$ -
0.0126100	$ 4,504	$ 3,740	$ 1,792	$ 1,561	$ -
0.0115935	$ 4,793	$ 3,980	$ 1,984	$ 1,728	$ -
0.0106713	$ 5,084	$ 4,221	$ 2,177	$ 1,896	$ -
0.0100051	$ 5,374	$ 4,462	$ 2,370	$ 2,064	$ -
0.0093465	$ 5,663	$ 4,703	$ 2,562	$ 2,231	$ -
0.0168912	$ 6,063	$ 5,034	$ 2,827	$ 2,462	$ -
0.0148589	$ 6,640	$ 5,513	$ 3,211	$ 2,796	$ -
0.0132227	$ 7,217	$ 5,993	$ 3,594	$ 3,131	$ -
0.0118048	$ 7,796	$ 6,473	$ 3,979	$ 3,465	$ -
0.0105378	$ 8,372	$ 6,952	$ 4,362	$ 3,799	$ -
0.0095217	$ 8,952	$ 7,433	$ 4,746	$ 4,134	$ -
0.0087883	$ 9,528	$ 7,911	$ 5,129	$ 4,467	$ -
0.0079758	$ 10,093	$ 8,381	$ 5,505	$ 4,794	$ -
0.0073031	$ 10,671	$ 8,860	$ 5,888	$ 5,129	$ -
0.0066969	$ 11,247	$ 9,338	$ 6,271	$ 5,462	$ -
0.0119478	$ 12,113	$ 10,058	$ 6,846	$ 5,963	$ -
0.0103521	$ 13,268	$ 11,017	$ 7,614	$ 6,631	$ -
0.0090362	$ 14,423	$ 11,976	$ 8,381	$ 7,300	$ -
0.0080641	$ 15,579	$ 12,936	$ 9,149	$ 7,968	$ -

	Base CPDs		Individual			
		Billed (2013)	Alwd (Calibrated to CPD) 2015	Paid (Calibrated to CPD) 2015	Paid	ReinsPmt
	Annual Frequency	Annual Claim	Annual Claim	Annual Claim	Annual Claim	Annual Claim
	0.0071800	$ 16,733	$ 13,894	$ 9,915	$ 8,636	$ -
	0.0150311	$ 18,703	$ 15,530	$ 11,224	$ 9,776	$ -
	0.0120290	$ 21,601	$ 17,936	$ 13,436	$ 11,702	$ -
	0.0097940	$ 24,485	$ 20,331	$ 15,831	$ 13,788	$ -
	0.0081200	$ 27,387	$ 22,740	$ 18,240	$ 15,887	$ -
	0.0067567	$ 30,278	$ 25,141	$ 20,641	$ 17,978	$ -
	0.0057334	$ 33,171	$ 27,543	$ 23,043	$ 20,070	$ -
	0.0089714	$ 37,400	$ 31,054	$ 26,554	$ 23,128	$ -
	0.0065556	$ 43,196	$ 35,867	$ 31,367	$ 27,320	$ -
	0.0050693	$ 48,979	$ 40,669	$ 36,169	$ 31,502	$ -
	0.0038455	$ 54,768	$ 45,475	$ 40,975	$ 35,688	$ -
	0.0031150	$ 60,512	$ 50,245	$ 45,745	$ 39,843	$ -
	0.0025422	$ 66,318	$ 55,066	$ 50,566	$ 44,041	$ -
	0.0021396	$ 72,099	$ 59,866	$ 55,366	$ 48,222	$ -
	0.0018302	$ 77,856	$ 64,646	$ 60,146	$ 52,385	$ -
	0.0015627	$ 83,674	$ 69,477	$ 64,977	$ 56,593	$ -
	0.0013558	$ 89,395	$ 74,227	$ 69,727	$ 60,730	$ -
	0.0021989	$ 97,948	$ 81,329	$ 76,829	$ 66,916	$ -
	0.0017466	$ 109,501	$ 90,922	$ 86,422	$ 75,271	$ 2,635
	0.0024584	$ 126,000	$ 104,622	$ 100,122	$ 87,203	$ 8,601
	0.0016931	$ 148,597	$ 123,385	$ 118,885	$ 103,545	$ 16,772
	0.0012256	$ 171,166	$ 142,125	$ 137,625	$ 119,867	$ 24,933
	0.0008958	$ 193,385	$ 160,574	$ 156,074	$ 135,935	$ 32,968
	0.0006802	$ 215,519	$ 178,952	$ 174,452	$ 151,942	$ 40,971
	0.0005189	$ 237,395	$ 197,117	$ 192,617	$ 167,763	$ 48,882
	0.0004177	$ 259,534	$ 215,500	$ 211,000	$ 183,774	$ 56,887
	0.0005493	$ 288,652	$ 239,678	$ 235,178	$ 204,832	$ 67,416
	0.0005556	$ 334,772	$ 277,972	$ 273,472	$ 238,185	$ 84,093
	0.0003710	$ 389,971	$ 323,806	$ 319,306	$ 278,105	$ 90,000
	0.0002462	$ 443,941	$ 368,619	$ 364,119	$ 317,136	$ 90,000
	0.0001836	$ 498,898	$ 414,252	$ 409,752	$ 356,880	$ 90,000
	0.0001865	$ 564,295	$ 468,553	$ 464,053	$ 404,175	$ 90,000
	0.0001657	$ 656,043	$ 544,735	$ 540,235	$ 470,527	$ 90,000
	0.0001024	$ 764,161	$ 634,509	$ 630,009	$ 548,717	$ 90,000
	0.0000718	$ 869,130	$ 721,668	$ 717,168	$ 624,630	$ 90,000
	0.0000509	$ 1,024,053	$ 850,306	$ 845,806	$ 736,669	$ 90,000
	0.0000809	$ 1,170,459	$ 971,872	$ 967,372	$ 842,549	$ 90,000
	0.0000375	$ 1,564,370	$ 1,298,949	$ 1,294,449	$ 1,127,422	$ 90,000
	0.0000103	$ 2,079,544	$ 1,726,716	$ 1,722,216	$ 1,499,993	$ 90,000
	0.0000047	$ 2,695,600	$ 2,238,247	$ 2,233,747	$ 1,945,520	$ 90,000
	0.0000030	$ 3,243,431	$ 2,693,130	$ 2,688,630	$ 2,341,708	$ 90,000
	0.0000013	$ 3,668,134	$ 3,045,775	$ 3,041,275	$ 2,648,850	$ 90,000
	0.0000010	$ 4,184,674	$ 3,474,676	$ 3,470,176	$ 3,022,408	$ 90,000
	0.0000007	$ 5,405,763	$ 4,488,587	$ 4,484,087	$ 3,905,491	$ 90,000
Annual	1.0000000	$ 9,071	$ 7,532	$ 5,927	$ 5,162	$ 412
Monthly		$ 755.88	$ 627.63	$ 493.91	$ 430.18	$ 34.30

Development of Base Rate from Market Adjusted Index Rate

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

1)	Market Adjusted Index Rate	$ 601.89	Exhibit O
2)	Reinsurance Contribution	$ 3.67	Exhibit F
3)	Expected Reinsurance Payments	$ (34.30)	Exhibit F
4)	Risk Adjustment Fee	$ 0.08	Exhibit F
5)	Risk Adjustment Net Transfer	$ -	Exhibit F
6)	Exchange Fee	$ 12.91	
7)	x Paid to Allowed Ratio	0.6854	
8)	= Projected Allowed Claims Reflecting only EHBs	$ 627.63	= (1) - [(2) + (3)+ (4)+ (5)+ (6)] ÷ (7)
9)	= Projected Paid Claims Reflecting only EHBs	$ 430.18	= (8) x (7)
10)	+ Risk Adjustment and Reinsurance - Contributions and Payments	$ (30.55)	Exhibit F
11)	+ Non-Benefit Expenses and Profit & Risk	$ 94.92	Exhibit G
12)	= Required Premium in Projection Period	$ 494.55	= (9) + (10) + (11)
13)	÷ Calibration Factor	1.7079	Exhibit H
14)	÷ Tobacco Average Rating Factor	1.0336	Exhibit H
15)	= Required Base Rate (Average Plan Level - Age 21 - Non-Tobacco)	$ 280.15	= (12) ÷ (13) ÷ (14)

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700024

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,300.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,300.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	100%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	100%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☑	☑		
Specialist Visit	☑	☑	100%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☑	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☑	☑		
Preferred Brand Drugs	☑	☑	100%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	100%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.2%
Metal Tier:	Bronze
	$2,894.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700023

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,250.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	59%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	62%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☑	☑		
Preferred Brand Drugs	☐	☐		$50.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.5%
Metal Tier:	Bronze
	$3,062.34
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700020

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	69%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☑	☑		
Preferred Brand Drugs	☐	☐		$55.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
$3,037.84	
$4,976.71	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN076
HIOS Plan ID: 17575IN0760002

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	2
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.3%
Metal Tier:	Bronze
	$2,949.40
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700025

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,500.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	73%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.8%
Metal Tier:	Bronze
	$2,976.08
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700021

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,300.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.6%
Metal Tier:	Bronze
	$3,063.79
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700026

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$3,500.00			
Coinsurance (%, Insurer's Cost Share)			100.00%			
OOP Maximum ($)			$4,500.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$45.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.3%
Metal Tier:	Silver
	$3,618.39
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700026-04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$3,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$4,150.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.3%
Metal Tier:	Silver
$3,723.16	
$5,146.76	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700026-05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$800.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$1,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold
$4,651.23	
$5,403.01	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700026-06

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$150.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$650.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum
$5,412.89	
$5,804.27	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700028

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$3,000.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	77%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	82%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.2%
Metal Tier:	Silver
	$3,512.61
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700028-04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,250.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	77%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	81%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.8%
Metal Tier:	Silver
$3,746.87	
$5,146.76	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700028-05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,150.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$1,150.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	100%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	100%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☑	☑		
Specialist Visit	☑	☑	100%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☑	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☑	☑		
Preferred Brand Drugs	☑	☑	100%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	100%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.2%
Metal Tier:	Gold
$4,655.68	
$5,403.01	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700028-06

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$500.00
Coinsurance (%, Insurer's Cost Share)			99.99%
OOP Maximum ($)			$500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	100%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	100%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☑	☑		
Specialist Visit	☑	☑	100%		☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☑	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☑	☑		
Preferred Brand Drugs	☑	☑	100%		☑	☑		
Non-Preferred Brand Drugs	☑	☑	100%		☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum
$5,413.84	
$5,804.27	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700027

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$40.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.2%
Metal Tier:	Silver
	$3,615.42
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700027-04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,450.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	79%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	84%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	3
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.8%
Metal Tier:	Silver
$3,744.41	
$5,146.76	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700027-05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$750.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$1,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	82%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$25.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.3%
Metal Tier:	Gold
$4,663.93	
$5,403.01	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700027-06

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$200.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	82%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$30.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.2%
Metal Tier:	Platinum
$5,411.13	
$5,804.27	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930005

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,000.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver
	$3,602.58
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930005-04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$4,250.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	69%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	73%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	3
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.9%
Metal Tier:	Silver
$3,752.82	
$5,146.76	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930005-05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$1,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	71%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$15.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$35.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	86.1%
Metal Tier:	Gold
$4,653.53	
$5,403.01	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930005-06

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$200.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$10.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☑	☑		
Preferred Brand Drugs	☐	☐		$25.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum
$5,419.32	
$5,804.27	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930006

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,000.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	79%		☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☑	☑		
Preferred Brand Drugs	☐	☐		$40.00	☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.5%
Metal Tier:	Gold
	$4,242.46
	$5,403.01

Indiana 2015 Formulary
Count of Drugs by Class and Tier

*approximates, but is not an exact match for, Category Class Drug Count Tool

			Tier				
Class ID	Category	Class	1	2	3	4	N
1	Analgesics	Nonsteroidal Anti-inflammatory Drugs	19	0	1		0
2	Analgesics	Opioid Analgesics, Long-acting	3	3	5		
3	Analgesics	Opioid Analgesics, Short-acting	11	3	2		
4	Anesthetics	Local Anesthetics	2		1		
5	Anti-Addiction/Substance Abuse Treatme	Alcohol Deterrents/Anti-craving	1		1		
6	Anti-Addiction/Substance Abuse Treatme	Opioid Antagonists	1	1			
7	Anti-Addiction/Substance Abuse Treatme	Smoking Cessation Agents	1		2		
8	Antibacterials	Aminoglycosides	4	2	2		
9	Antibacterials	Antibacterials, Other	10	3	10		
10	Antibacterials	Beta-lactam, Cephalosporins	7	8	2		
11	Antibacterials	Beta-lactam, Other		3	2		
12	Antibacterials	Beta-lactam, Penicillins	5	4	1		0
13	Antibacterials	Macrolides	3		2		0
14	Antibacterials	Quinolones	2	1	4		
15	Antibacterials	Sulfonamides	3	1			
16	Antibacterials	Tetracyclines	3	1	0		
17	Anticonvulsants	Anticonvulsants, Other	2	1	1		
18	Anticonvulsants	Calcium Channel Modifying Agents	1	1	2		
19	Anticonvulsants	Gamma-aminobutyric Acid (GABA) Augmentin	1	2	1		
20	Anticonvulsants	Glutamate Reducing Agents	3				
21	Anticonvulsants	Sodium Channel Agents	4	2	3		
22	Antidementia Agents	Antidementia Agents, Other		1			
23	Antidementia Agents	Cholinesterase Inhibitors	1	2			
24	Antidementia Agents	N-methyl-D-aspartate (NMDA) Receptor Antagonist			1		
25	Antidepressants	Antidepressants, Other	5		3		
26	Antidepressants	Monoamine Oxidase Inhibitors	2		2		
27	Antidepressants	Serotonin/Norepinephrine Reuptake Inhibitor	8		1		1
28	Antidepressants	Tricyclics	8	1			
29	Antiemetics	Antiemetics, Other	8	1	2		0
30	Antiemetics	Emetogenic Therapy Adjuncts		3	4		
31	Antifungals	No USP Class	10	3	11		0
32	Antigout Agents	No USP Class	4		2		
33	Anti-inflammatory Agents	Glucocorticoids	19		4		0
34	Anti-inflammatory Agents	Nonsteroidal Anti-inflammatory Drugs	19	0	1		0
35	Antimigraine Agents	Ergot Alkaloids			1		
36	Antimigraine Agents	Prophylactic	3			1	
37	Antimigraine Agents	Serotonin (5-HT) 1b/1d Receptor Agonists	3	0	3		
38	Antimyasthenic Agents	Parasympathomimetics	2		1		
39	Antimycobacterials	Antimycobacterials, Other			2		
40	Antimycobacterials	Antituberculars	5		7		
41	Antineoplastics	Alkylating Agents				7	
42	Antineoplastics	Antiangiogenic Agents				3	
43	Antineoplastics	Antiestrogens/Modifiers				3	
44	Antineoplastics	Antimetabolites				5	
45	Antineoplastics	Antineoplastics, Other	1			9	
46	Antineoplastics	Aromatase Inhibitors, 3rd Generation				3	
47	Antineoplastics	Enzyme Inhibitors				8	
48	Antineoplastics	Molecular Target Inhibitors				16	
49	Antineoplastics	Monoclonal Antibodies			1	3	
50	Antineoplastics	Retinoids			1	2	
51	Antiparasitics	Anthelmintics	1		3		
52	Antiparasitics	Antiprotozoals	6		5	1	
53	Antiparasitics	Pediculicides/Scabicides	3		2		
54	Antiparkinson Agents	Anticholinergics	2	1			
55	Antiparkinson Agents	Antiparkinson Agents, Other	1	1	1		
56	Antiparkinson Agents	Dopamine Agonists	3			1	
57	Antiparkinson Agents	Dopamine Precursors/ L-Amino Acid Decarbo›	1				
58	Antiparkinson Agents	Monoamine Oxidase B (MAO-B) Inhibitors	1		1		
59	Antipsychotics	1st Generation/Typical	9		1		
60	Antipsychotics	2nd Generation/Atypical	3	1	5		
61	Antipsychotics	Treatment-Resistant		1			
62	Antispasticity Agents	No USP Class	2	1	1	1	0

Indiana 2015 Formulary
Count of Drugs by Class and Tier

*approximates, but is not an exact match for, Category Class Drug Count Tool

			Tier				
Class ID	Category	Class	1	2	3	4	N
63	Antivirals	Anti-cytomegalovirus (CMV) Agents		3	1		
64	Antivirals	Antihepatitis Agents				11	0
65	Antivirals	Antiherpetic Agents	4	1	1		
66	Antivirals	Anti-HIV Agents, Non-nucleoside Reverse Transcriptase Inhibitors				5	
67	Antivirals	Anti-HIV Agents, Nucleoside and Nucleotide Reverse Transcriptase Inhibitors				10	
68	Antivirals	Anti-HIV Agents, Other				3	
69	Antivirals	Anti-HIV Agents, Protease Inhibitors				9	
70	Antivirals	Anti-influenza Agents	2	2			
71	Anxiolytics	Anxiolytics, Other	4				
72	Anxiolytics	SSRIs/SNRIs (Selective Serotonin Reuptake Inh	4				1
73	Bipolar Agents	Bipolar Agents, Other	3	1	3		
74	Bipolar Agents	Mood Stabilizers	5				
75	Blood Glucose Regulators	Antidiabetic Agents	9	1	10		
76	Blood Glucose Regulators	Glycemic Agents		1	1		
77	Blood Glucose Regulators	Insulins		9	1		
78	Blood Products/Modifiers/ Volume Expar	Anticoagulants	1	1	2	3	0
79	Blood Products/Modifiers/ Volume Expar	Blood Formation Modifiers				8	
80	Blood Products/Modifiers/ Volume Expar	Coagulants		1			
81	Blood Products/Modifiers/ Volume Expar	Platelet Modifying Agents	3	1	3	1	
82	Cardiovascular Agents	Alpha-adrenergic Agonists	4	1			
83	Cardiovascular Agents	Alpha-adrenergic Blocking Agents	3		1		
84	Cardiovascular Agents	Angiotensin II Receptor Antagonists	4		3		
85	Cardiovascular Agents	Angiotensin-converting Enzyme (ACE) Inhibito	10				
86	Cardiovascular Agents	Antiarrhythmics	4	6	2		
87	Cardiovascular Agents	Beta-adrenergic Blocking Agents	11		2		
88	Cardiovascular Agents	Calcium Channel Blocking Agents	8	1			
89	Cardiovascular Agents	Cardiovascular Agents, Other	2		2		
90	Cardiovascular Agents	Diuretics, Carbonic Anhydrase Inhibitors	2				
91	Cardiovascular Agents	Diuretics, Loop	3		1		
92	Cardiovascular Agents	Diuretics, Potassium-sparing	2	1	1		
93	Cardiovascular Agents	Diuretics, Thiazide	6				
94	Cardiovascular Agents	Dyslipidemics, Fibric Acid Derivatives	2				
95	Cardiovascular Agents	Dyslipidemics, HMG CoA Reductase Inhibitors	5		2		
96	Cardiovascular Agents	Dyslipidemics, Other	2		3		
97	Cardiovascular Agents	Vasodilators, Direct-acting Arterial	2		1		
98	Cardiovascular Agents	Vasodilators, Direct-acting Arterial/Venous	2	1			
99	Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agent	3		1		
100	Central Nervous System Agents	Attention Deficit Hyperactivity Disorder Agent	2		2		
101	Central Nervous System Agents	Central Nervous System Agents, Other	1	3	3		
102	Central Nervous System Agents	Fibromyalgia Agents			2		1
103	Central Nervous System Agents	Multiple Sclerosis Agents				7	
104	Dental and Oral Agents	No USP Class	5	2	0	1	
105	Dermatological Agents	No USP Class	41	1	28	3	0
106	Enzyme Replacement/ Modifiers	No USP Class	1	0	1	12	1
107	Gastrointestinal Agents	Antispasmodics, Gastrointestinal	3	1	1		
108	Gastrointestinal Agents	Gastrointestinal Agents, Other	4	1	4		
109	Gastrointestinal Agents	Histamine2 (H2) Receptor Antagonists	4				
110	Gastrointestinal Agents	Irritable Bowel Syndrome Agents			2		
111	Gastrointestinal Agents	Laxatives	1		2		
112	Gastrointestinal Agents	Protectants	2				
113	Gastrointestinal Agents	Proton Pump Inhibitors	2	1	2		
114	Genitourinary Agents	Antispasmodics, Urinary	3	1	3		
115	Genitourinary Agents	Benign Prostatic Hypertrophy Agents	6		3		
116	Genitourinary Agents	Genitourinary Agents, Other		1	4		
117	Genitourinary Agents	Phosphate Binders		1	2		
118	Hormonal Agents, Stimulant/ Replacemer	Glucocorticoids/Mineralocorticoids	21	1	6		0
119	Hormonal Agents, Stimulant/Replacemer	No USP Class	1	1		2	
120	Hormonal Agents, Stimulant/Replacemer	No USP Class	1				
121	Hormonal Agents, Stimulant/Replacemer	Anabolic Steroids		1			
122	Hormonal Agents, Stimulant/Replacemer	Androgens	1	1	2		
123	Hormonal Agents, Stimulant/Replacemer	Estrogens	5		4		1
124	Hormonal Agents, Stimulant/Replacemer	Progestins	6		2		0

Indiana 2015 Formulary
Count of Drugs by Class and Tier

*approximates, but is not an exact match for, Category Class Drug Count Tool

			Tier				
Class ID	Category	Class	1	2	3	4	N
125	Hormonal Agents, Stimulant/Replacemer	Selective Estrogen Receptor Modifying Agents		1			
126	Hormonal Agents, Stimulant/Replacemer	No USP Class	2		1		
127	Hormonal Agents, Suppressant (Adrenal)	No USP Class				1	
128	Hormonal Agents, Suppressant (Parathyr	No USP Class	1			1	
129	Hormonal Agents, Suppressant (Pituitary)	No USP Class	2			7	
130	Hormonal Agents, Suppressant (Sex Horn	Antiandrogens	1		1	3	
131	Hormonal Agents, Suppressant (Thyroid)	Antithyroid Agents	2				
132	Immunological Agents	Immune Suppressants			2	19	1
133	Immunological Agents	Immunizing Agents, Passive				1	
134	Immunological Agents	Immunomodulators	2	1	1	8	
135	Inflammatory Bowel Disease Agents	Aminosalicylates	1		2		
136	Inflammatory Bowel Disease Agents	Glucocorticoids	4	1			
137	Inflammatory Bowel Disease Agents	Sulfonamides	1				
138	Metabolic Bone Disease Agents	No USP Class	3	3	4	3	1
139	Ophthalmic Agents	Ophthalmic Prostaglandin and Prostamide Ana	1		2		
140	Ophthalmic Agents	Ophthalmic Agents, Other	10		8		
141	Ophthalmic Agents	Ophthalmic Anti-allergy Agents	3		6		
142	Ophthalmic Agents	Ophthalmic Antiglaucoma Agents	12		5		
143	Ophthalmic Agents	Ophthalmic Anti-inflammatories	6	1	4		
144	Otic Agents	No USP Class	4		3		
145	Respiratory Tract Agents	Antihistamines	9	1	1		0
146	Respiratory Tract Agents	Anti-inflammatories, Inhaled Corticosteroids	4	2	1		
147	Respiratory Tract Agents	Antileukotrienes	2		1		
148	Respiratory Tract Agents	Bronchodilators, Anticholinergic	1		1		
149	Respiratory Tract Agents	Bronchodilators, Phosphodiesterase Inhibitors	2		1		
150	Respiratory Tract Agents	Bronchodilators, Sympathomimetic	3	3	4		
151	Respiratory Tract Agents	Mast Cell Stabilizers	1				
152	Respiratory Tract Agents	Pulmonary Antihypertensives				6	
153	Respiratory Tract Agents	Respiratory Tract Agents, Other		2	2	1	
154	Skeletal Muscle Relaxants	No USP Class	6				0
155	Sleep Disorder Agents	GABA Receptor Modulators	2		1		
156	Sleep Disorder Agents	Sleep Disorders, Other	1		4		
157	Therapeutic Nutrients/ Minerals/ Electrol	Electrolyte/Mineral Modifiers	1		4	2	0
158	Therapeutic Nutrients/ Minerals/ Electrol	Electrolyte/Mineral Replacement	2	4	4		0

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Anthem Insurance Companies, Inc.
State:	Indiana
HIOS Issuer ID:	17575
NAIC Company Code:	28207
Market:	Individual
Effective Date:	January 1, 2015

- Company Contact Information

Primary Contact Name:	Aaron Smith
Primary Contact Telephone Number:	(317) 287-6452
Primary Contact Email Address:	Aaron.Smith@wellpoint.com

2. Scope and Purpose of the Filing

To the best of Anthem's knowledge and current understanding, this filing complies with the most recent regulations and related guidance. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required.

The purpose of this rate filing is to establish rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):

IN_ONHIX_HMHS(1/15)
IN_OFFHIX_HMHS(1/15)
IN_ONHIX_PS(1/15)
IN_OFFHIX_PS(1/15)

3. Introduction

This filing includes an average rate increase of 9.7%, with range by plan between -3.6% and 19.6%. More details are provided below in Section 5: Proposed Rate Increase, and in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

- Changes from 2014 Filings

Medicaid Spend Down Program - Adjustment due to 1634 Transition. See Section 9: Credibility Manual Rate Development for details.

Tobacco rating factors now vary by age – see Exhibit J: Age and Tobacco Factors.

Area factors have been adjusted to reflect most current experience. Refer to Exhibit K: Area Factors.

This filing includes new exhibits showing the Market Adjusted Index Rate, Plan Adjusted Index Rate, and Consumer Adjusted Premium Rates, as defined in the new memo instructions for 2015 filings. See Exhibit N: Market Adjusted Index Rate Development and Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

4. Description of How the Base Rate Is Determined

The development of the Base Rate is detailed in Exhibit A: Base Rate Development. Further details on how the base rate is developed can be found in Section 9: Credibility Manual Rate Development, Section 12: Risk Adjustment and Reinsurance, Section 13: Non-Benefit Expenses, Profit and Risk, and Section 19: Calibration. A description of the methodology used to determine the base rate is as follows:

- Historical Individual experience is not considered representative of the future market; therefore, the manual rates are developed based on Small Group Grandfathered and Non-Grandfathered experience.
- The experience data is normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period based on expected distribution of membership.
- The projected claims cost is calculated by adjusting the normalized claims for the impact of benefit changes, population morbidity, trend factors, other cost of care impacts and other claim adjustments.
- The projection period is January 1, 2015 - December 31, 2015.
- Adjustments for risk adjustment and reinsurance are applied to the projected claims cost.
- Non-benefit expenses, profit, and risk are applied to the projected claims cost to determine the required projection period premium.
- The projection period premium is adjusted by the average rating factors in the projection period to determine the base rate.
- The base rate represents an average benefit plan and area for an age 21 non-tobacco user in Indiana.

Premiums at the member level are determined by multiplying the base rate by the applicable factor for each of the allowable rating criteria: age, tobacco, area and benefit plan. An example of this calculation is shown in Exhibit L: Sample Rate Calculation.

5. Proposed Rate Increase

The average proposed rate increase is 9.7%. Factors that affect the proposed rate increase for all plans include:

- Changes in benefit design
- Anticipated changes in the market-wide morbidity of the covered population in the projection period
- Changing trends in medical costs and utilization and other cost of care impacts
- Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program
- Changes in taxes, fees, and other non-benefit expenses

The rate increase is shown in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

Although rates are based on the same single risk pool of experience, proposed rate increases vary by plan from -3.6% to 19.6%. Factors that affect the variation in the proposed rate increase by plan include:

- Changes in benefit design that vary by plan
- Changes in the adjustment factor for Catastrophic eligibility
- Changes in Non-Benefit Expenses that are applied on a PMPM basis
- Changes in the underlying area rating factors

In 2014, the area factors varied by plan based on actuarially justified network cost differences for each geographic rating area. Effective January 1, 2015, a single area factor will apply to all plans in each geographic rating area. To retain the actuarially justified network cost differences for each geographic area and comply with 45 CFR part §147.102, several new plans have been added, each of which is available in a single geographic rating area. New plans have been mapped to comparable 2014 plans for purposes of determining the rate increase. Refer to Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases and Exhibit K: Area Factors for details.

These rate increases by plan are shown in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

6. Experience Period Premium and Claims

Experience shown in Worksheet 1, Section I of the Unified Rate Review Template is for the Indiana Individual Single Risk Pool Non-Grandfathered Business. This experience is given 0% credibility in the development of manual rates. This is not due to the amount of experience in Worksheet 1, Section I of the Unified Rate Review Template, but rather 0% credibility is applied to this experience because we have instead used combined Grandfathered and Non-Grandfathered Small Group experience in the development of manual rates, as described in Section 10: Credibility of Experience. The manual rates are fully detailed in Section 9: Credibility Manual Rate Development.

Claims experience in Worksheet 1, Section I of the Unified Rate Review Template reflects dates of service from January 1, 2013 through December 31, 2013.

- Paid Through Date

  Claims shown in Worksheet 1, Section I of the Unified Rate Review Template are paid through March 31, 2014.

- Allowed and Incurred Claims Incurred During the Experience Period

  The allowed claims are determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

  Allowed and incurred claims are completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of claims paid for a particular month after one month of run out, two months, etc., for a forty-eight month view of history. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

- Premiums (net of MLR Rebate) in Experience Period

  The estimated Non-Grandfathered gross earned premium for Indiana Individual is $200,796,023, where earned premium is the pro-rata share of premium owed to Anthem due to subscribers actively purchasing insurance coverage during the experience period.

  The preliminary MLR Rebate estimate is $0, which is consistent with the December 31, 2013 Anthem general ledger estimate allocated to the Non-Grandfathered portion of Individual. Note that this is an estimate and will not be final until June 1, 2014.

7. Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- Capitation: Includes all services provided under one or more capitated arrangements.
- Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

8. Projection Factors

As previously indicated, the credibility level assigned to the experience in Worksheet 1, Section III of the Unified Rate Review Template is 0%. Consequently, factors to project experience claims are not provided as they are not applicable. However, the factors used to develop the manual rates are fully detailed in Section 9: Credibility Manual Rate Development.

• Changes in the Morbidity of the Population Insured

n/a - see Credibility Manual Rate Development

• Changes in Benefits

n/a - see Credibility Manual Rate Development

• Changes in Demographics

n/a - see Credibility Manual Rate Development

• Other Adjustments

n/a - see Credibility Manual Rate Development

• Trend Factors (cost/utilization)

n/a - see Credibility Manual Rate Development

9. Credibility Manual Rate Development

Experience developed and projected herein is Anthem's Small Group Business based on plan liability amounts. The rate development is shown in Exhibit A: Base Rate Development.

• Source and Appropriateness of Experience Data Used

As mentioned in Section 4: Description of How the Base Rate Is Determined and Section 6: Experience Period Premium and Claims, historical Individual experience is not considered representative of the 2015 market environment due to ACA requirements of guarantee issue, EHB, minimum actuarial value constraints, and other mandate changes. Historical Small Group experience is more reflective of the 2015 population since Small Group business is already guarantee issue with no medical underwriting, and benefit designs are closer to the 2015 ACA requirements. Therefore, Anthem is using all Grandfathered and Non-Grandfathered Small Group experience to develop manual rates.

The source data underlying the development of the manual rate consists of claims for all Grandfathered and Non-Grandfathered Small Group business, incurred during the period January 1, 2013 – December 31, 2013 and paid through March 31, 2014. Completion factors are then calculated to reflect additional months of runout after March 31, 2014. Anthem expects a portion of the Grandfathered policyholders to migrate to ACA-compliant policies prior to and during the projection period.

In developing rates effective January 1, 2015, only limited 2014 experience is available. This experience is not deemed credible for purposes of rate development.

Experience is adjusted as follows:

- Claims incurred for members who live out-of-state were excluded; however, claims incurred by in-state members traveling out-of-state were included.

For more detail, see Exhibit B: Claims Experience for Manual Rate Development.

• Adjustments Made to the Data

The development of the projected claims is summarized in Exhibit A: Base Rate Development, items (1) - (10), and described in detail below.

The projected claims cost is calculated by multiplying the normalized claims cost by the impact of benefit changes, anticipated changes in population morbidity, and cost of care impacts. The adjustments are described below, and the factors are presented in Exhibit D: Projection Period Adjustments. In addition, the source data is normalized for seasonality and changes in the provider contracts.

Changes in Demographics (Normalization)

The source data was normalized to reflect anticipated changes in age/gender, area, network, and benefit plan from the experience period to the projection period. The purpose of these factors is to adjust current experience to be reflective of expected claim experience in the projection period. See Section 23: Membership Projections for additional information on membership movement. The normalization factors and their aggregate impact on the underlying experience data are detailed in Exhibit C: Normalization Factors.

- Age/Gender: The assumed claims cost is applied by age and gender to the experience period distribution and the projection period distribution.
- Area/Network: The area claims factors are developed based on an analysis of Small Group and Individual allowed claims by network, mapped to the prescribed 2015 rating areas using 5-digit zip code.
- Benefit Plan: The experience period claims are normalized to an average 2015 plan using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

Changes in Benefits

Benefit changes include the following:

- Preventive Rx (over the counter): The claims are adjusted for 100% coverage of benefits for specific over the counter drugs obtained with a prescription from a physician.
- Rx Adjustments: The claims are adjusted for differences in the Rx formulary and the impact of moving drugs into different tiers in the projection period relative to what is reflected in the base experience data.

Changes in the Morbidity of the Population Insured

Morbidity changes include the following (for Morbidity factor, see Exhibit D: Projection Period Adjustments):

- Higher morbidity expected from individual-level purchasing decisions in 2015: Anthem assumes that the morbidity of the smallest groups, sizes 2 – 5 members, relative to the total small group population are a reasonable approximation for the health status of the individual market. Relative morbidity by group size is based on health status determined from internal risk score data.
- Higher morbidity of the uninsured compared to the insured population: This adjustment is based on a CDC study on the health status and life styles of both currently insured and uninsured populations. This adjustment also considers the expected number of previously uninsured individuals expected to move into the Individual market in 2015.

- Pent-up demand: As previously uninsured individuals obtain insurance in 2015, Anthem expects them to have some pent-up demand for health care services. An adjustment is needed to account for this additional utilization of health care services in year one. Previously uninsured individuals are assumed to utilize more health care services due to pent-up demand. Currently insured members are assumed to have no pent-up demand for health care services in year one.

- Morbidity of Non-Grandfathered compared to Grandfathered members: The base period experience includes Grandfathered and Non-Grandfathered members. The experience is adjusted to account for the different morbidity between Grandfathered and Non-Grandfathered members to derive a Non-Grandfathered only rate.

Our goal is to price to the average risk of the 2015 ACA market. Since Anthem-specific 2013 experience was used as a starting point, we adjusted this experience to be more consistent with the overall 2013 market in Indiana. Wakely Consulting collected demographic and risk information from carriers, and calculated Anthem's relative risk to the market for 2013. We have adjusted our starting experience using the results of that survey.

Trend Factors

- The annual pricing trend used in the development of the rates is 11.3%. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, and the result is projected forward. The trend includes a volatility provision in accordance with Actuarial Standards of Practice. The claims are trended 24 months from the midpoint of the experience period, which is July 1, 2013, to the midpoint of the projection period, which is July 1, 2015.

- Projected trends include the estimated cost during 2014 and 2015 of the pharmaceutical Sovaldi and other high-cost drugs for treating Hepatitis C. These cost estimates were based on claims experience for Anthem's Individual business, together with CDC recommendations and Industry and Enterprise data.

Other Cost of Care Impacts

- Induced Demand Due to Cost Share Reductions: Individuals below 200% Federal Poverty Level who enroll in silver plans On-Exchange will be eligible for cost share reductions. As a result, the base period experience is adjusted to account for the higher anticipated utilization levels.

- Medicaid Spend Down: An adjustment is needed to account for the planned 1634 Transition on June 1, 2014. As a result of this transition, the State will be ceasing operations of the Spend Down Program and approximately 6,800 plan participants will move into the commercial market. The transitioning Spend Down participants have average claims on an annual basis of approximately $21,000 per member per year at current Medicaid reimbursement levels.

- Pervasive Development Disorder Mandate: A Cost of Care adjustment is needed to account for the fact that there are not significant costs related to Pervasive Development Disorders (PDD) in the Small Group base period experience. In the Individual and Small Group markets today, insurers cannot deny or restrict coverage because an individual is diagnosed with PDD. This mandate results in adverse selection, which uniquely impacts the Individual market. Recently, utilization of an expensive type of therapy called applied behavior analysis (ABA) used to treat individuals with PDD has increased significantly in the market. Anthem is required by the state mandate to cover these expensive medical services. In 2013, Anthem paid approximately $13 million in medical costs for ABA therapy. The costs for currently insured individuals receiving ABA therapy have been projected into the projection period to determine this adjustment.

- Utilization or cost-per-service change: anticipated changes are reflected in the morbidity changes and trend.
- Change in Medical Management: medical management savings not already included in the claims experience and trend.
- Change in Provider Contracts: anticipated changes in provider contracts are reflected in the benefit plan factors and the region rating factors.

Other Claim Adjustments

The adjustments described below are presented in Exhibit E: Other Claim Adjustments.

- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.

- The cost of adding benefits for pediatric dental and vision are included.

• Capitation Payments

The underlying data includes capitation payments, which are combined with the base medical and pharmacy claims and projected at the same rate. No further adjustment is made to the capitation.

10. Credibility of Experience

The underlying experience data does not reasonably reflect Individual claims experience under the future market conditions. Anthem believes that Small Group experience is more representative of the future projection period. Actuarial judgment has been exercised to determine that rates will be developed giving full credibility to the data underlying the manual rate in Section 9: Credibility Manual Rate Development.

• Resulting Credibility Level Assigned to Base Period Experience

The credibility level assigned to the experience in Worksheet 1, Section III of the Unified Rate Review Template is 0%.

11. Paid to Allowed Ratio

The 'Paid to Allowed Average Factor in Projection Period' shown in Worksheet 1, Section III of the Unified Rate Review Template is developed by membership-weighted essential health benefit paid claims divided by membership-weighted essential health benefit allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

12. Risk Adjustment and Reinsurance

- Projected Risk Adjustment

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. The HHS operated Risk Adjustment program is supported by a user fee, as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

Anthem is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The transitional reinsurance risk mitigation program collects funds from all insurance issuers and TPAs and redistributes them to high cost claimants in the Non-Grandfathered Individual market. The reinsurance contribution is equal to the national per capita reinsurance contribution rate as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

The reinsurance payment is developed using projected paid claims, claim probability distribution, and reinsurance payment guidelines. The claim probability distribution observes claims between $70K and $250K using a claim probability distribution that reflects the anticipated claim cost distribution of the 2015 Individual market. The coinsurance rate is 50%. Expected paid claims are calculated for an assumed average On-Exchange plan design. Reinsurance payments are allocated proportionally by plan premiums to all plans in the risk pool.

13. Non-Benefit Expenses, Profit and Risk

Non-Benefit expenses are detailed in Exhibit G: Non-Benefit Expenses and Profit & Risk.

- Administrative Expense

Administrative Expense contains both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales, etc) as well as maintenance costs associated with ongoing costs for the administration of the business. Acquisition costs are projected using historical cost per member sold amounts applied to future sales estimates. Maintenance costs are assumed to be flat on a per member basis with savings from fixed cost leverage and the elimination of underwriting offset by new expenses for risk management, regulatory compliance and premium reconciliation and balancing.

- Quality Improvement Expense

The quality improvement expense represents Anthem's dedication to providing the highest standard of customer care and consistently seeking to improve health care quality, outcomes and value in a cost efficient manner.

The QI Expense assumptions are based on historical amounts related to the following initiatives: Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, HIT Expenses for Health Care Quality Improvements, Other Cost Containment and ICD-10.

- Selling Expense

Selling Expense represents broker commissions and bonuses associated with the broker distribution channel using historical and projected commission levels. Commissions will be paid both On-Exchange and Off-Exchange.

- Taxes and Fees

- Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund. For plan years ending before October 1, 2014, the fee is $2 per member per year. Thereafter, for every plan year ending before October 1, 2019, the fee will increase by the percentage increase in National Healthcare Expenditures.
- ACA Insurer Fee: The health insurance industry will be assessed a permanent fee, based on market share of net premium, which is not tax deductible. The tax impact of non-deductibility is captured in this fee.
- Exchange Fee: The Exchange User Fee applies to Exchange business only, but the cost is spread across all Individual plans. A blended fee/percentage is determined based on an assumed 74% of members that will purchase products On-Exchange. The resulting fee/percentage is applied evenly to all plans in the risk pool, both On and Off Exchange.

- Premium taxes, federal income taxes and state income taxes are also included in the retention items.

- Profit

Profit is reflected on a post-tax basis as a percent that does not vary by product or plan. The profit percentage does not include any assumed risk corridor payments or receipts.

14. Projected Loss Ratio

- Projected Federal MLR

The projected Federal MLR for the products in this filing is estimated in Exhibit M: Federal MLR Estimated Calculation. Please note that this calculation is purely an estimate and not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only a subset of Anthem's Individual business. The MLR for Anthem's entire book of Individual business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

15. Single Risk Pool

As described above in Section 4: Description of How the Base Rate Is Determined, the Anthem Index Rate for Individual business in Indiana is based on total combined claims costs for providing essential health benefits within the single risk pool of non-grandfathered Individual plans in Indiana. The Index Rate is adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and Exchange user fees. The premium rates for all Anthem non-grandfathered plans in the Individual market use the applicable market-wide adjusted index rate, subject only to the permitted plan-level adjustments. This demonstrates that the Single Risk Pool for Anthem Individual business is established according to the requirements in 45 CFR part 156, §156.80(d).

16. Index Rate

- Experience Period Index Rate

The index rate represents the average allowed claims PMPM of essential health benefits for Anthem's Individual Non-Grandfathered Business. The experience period index rate shown in Worksheet 1, Section I (cell G17) of the Unified Rate Review Template is $270.00 and is the same as the experience period allowed claims (cell G16 in the same location). A comparison to the benchmark was performed, and only essential health benefits were covered during the experience period.

• Projection Period Index Rate

The index rate represents the average allowed claims PMPM of essential health benefits for Anthem's Individual Non-Grandfathered Business. The projection period index rate was developed as shown in Exhibit N: Market Adjusted Index Rate Development by adjusting the projected incurred claims PMPM described in Section 9: Credibility Manual Rate Development of this memorandum. No benefits in excess of the essential health benefits are included in the projection period allowed claims (cell T30 of Worksheet 1, Section II of the Unified Rate Review Template) or Exhibit N: Market Adjusted Index Rate Development's projection period index rate (also shown in cell V44 of Worksheet 1, Section III of the Unified Rate Review Template).

17. Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market wide modifiers defined in the market rating rules. This development is presented in Exhibit N: Market Adjusted Index Rate Development.

18. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. This development is presented in Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

• Plan Level Modifiers

- Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan, based on the AV metal value with an adjustment for utilization differences due to differences in cost sharing. This also includes an adjustment for the average tobacco factor shown in Exhibit H: Calibration .
- Provider Network Adjustments: This is a multiplicative factor that adjusts for differences in projected claims cost due to different network discounts.
- Adjustments for Benefits in Addition to EHBs: This multiplicative factor adjusts for additional benefits that are not EHBs.
- Adjustments for administrative cost: This is an additive adjustment that includes all the Selling Expense, Administration and Other Retention Items shown in Exhibit G: Non-Benefit Expenses and Profit & Risk, with the exception of the Exchange User Fee.

19. Calibration

The required premium in the projection period is calibrated by the average rating calibration factors (Age, Area, and Plan Factor), which are used to develop the Consumer Adjusted Premium Rates. The average rating factors are shown in Exhibit H: Calibration, Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates, and applied in line item 14 of Exhibit A: Base Rate Development.

• Benefit Plan Factors

The benefit plan rating factors are applied to the projection period distribution.

Benefit plan factors also consider the following adjustments, as applicable.

- Induced Utilization Adjustment: The induced utilization adjustment accounts for member behavior variations depending on the richness of the benefit design.
- Pediatric Dental and Vision Benefits: For plans excluding the pediatric dental benefit and pediatric vision benefit, the benefit plan factor reflects reduced benefits.
- Non-EHBs: For plans including benefits in addition to EHBs, the benefit plan factor reflects enhanced benefits.
- Catastrophic Factor: This adjustment assumes a healthier than average population will select the catastrophic plan. The catastrophic adjustment factor is normalized to 1.0 across all plans in the Single Risk Pool.
- Provider Network: This factor accounts for differences in contracted rates and network structure.

Refer to Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

• Age Factors

- Refer to Exhibit J: Age and Tobacco Factors.

• Area Factors

In 2014, the area factors varied by plan based on actuarially justified network cost differences for each geographic rating area. Effective January 1, 2015, a single area factor will apply to all plans in each geographic rating area.

Area factors have been adjusted to reflect the most current experience. Refer to Exhibit K: Area Factors.

20. Consumer Adjusted Premium Rate

The Consumer Adjusted Premium Rate is calculated as the Plan Adjusted Index Rate calibrated as described in the previous section. This development is presented in Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates. The calibration is shown in Exhibit H: Calibration.

21. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values included in Worksheet 2 of the Unified Rate Review Template are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. Benefits for Plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

22. Actuarial Value Pricing Values

The AV Pricing Values for each Product ID are in Worksheet 2, Section I of the Unified Rate Review Template. The fixed reference plan selected as the basis for the AV Pricing Value calculations is '17575IN0770020'. Consistent with final Market rules, utilization adjustments are made to account for member behavior variations based upon cost-share variations of the benefit design and not the health status of the member. The average allowable modifiers to the Index Rate can be found in Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

23. Membership Projections

Membership projections in Worksheet 2 of the Unified Rate Review Template are developed using a population movement model plus adjustments for sales expectations. This model projects the membership in the projection period by taking into account:

- Uninsured to Individual as a result of guaranteed issue, subsidized coverage, and individual mandate
- Small Group to Individual as a result of guaranteed issue and rate disruptions due to the transition to Modified Community Rating
- High Risk Pools to Individual as a result of guaranteed issue
- Individual and Uninsured to Medicaid

The plan distribution is based on assumed metal tier and network distributions. Some 2014 preliminary enrollment information has been considered in projecting membership distributions.

The projected morbidity changes shown in Exhibit D: Projection Period Adjustments include expected morbidity changes due to population movement.

Cost share reduction subsidies will be available on silver level plans. Anthem ran projections to estimate enrollment by income level in each of the plans. Projected enrollment by plan and subsidy level can be found in Exhibit P: Membership Projections for Cost-Sharing Reductions.

24. Warning Alerts

There are warning alerts in cells A80 and A82 on Worksheet 2, Section IV of the Unified Rate Review Template. This is because the Plan Adjusted Index Rate is defined to remove the portion of premium that is expected to be collected through the tobacco surcharge, whereas the Worksheet 1 Single Risk Pool Gross Premium Avg. Rate reflects total premium.

25. Plan Type

Plan types in Worksheet 2, Section I of the URRT adequately describe Anthem's plans.

26. Reliance

In support of this rate development, various data and analyses were provided by other members of Anthem's internal actuarial staff, including data and analysis related to cost of care, valuation, and pricing. I have reviewed these data and analyses for reasonableness and consistency. I have also relied on Brian Renshaw, FSA, MAAA to provide the actuarial certification for the Unique Plan Design Supporting Documentation and Justification for plans included in this filing.

27. Actuarial Certification

I, Nicole Styka, FSA, MAAA, am an actuary for Anthem. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The projected Index Rate is:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient.

(2) The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

(3) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

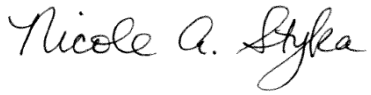
(4) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

(5) On/Off Exchange Attestation: A single base premium rate has been developed for both on and off exchange plans using the same underlying experience data. The premium rates for on and off exchange plans vary only due to differences in the provider network and benefit design.

(6) QHP Off Exchange Premium Tax Credit (PTC) Attestation: To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, we will include in marketing materials language substantially as follows:

The Patient Protection and Affordability Care Act (PPACA) includes provisions to lower premiums for people with low to modest incomes through a tax credit. The tax credit is only available for qualifying individuals who purchase their individual coverage through the Exchange. Please note that this plan is not eligible for financial assistance through the premium tax credit provision because it is not purchased through the Exchange.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-Facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, used consistently, and only adjusted by the allowable modifiers. However, this Actuarial Memo does accurately describe the process used by the issuer to develop the rates.



Nicole Styka, FSA, MAAA
Regional Vice President and Actuary III

June 5, 2014
Date

Exhibit A - Base Rate Development

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

			Paid Claims	
1)	Experience Period Cost PMPM	$	275.71	Exhibit B
2)	x Normalization Factor		1.0117	Exhibit C
3)	= Normalized Claims	$	278.94	= (1) x (2)
4)	x Benefit Changes		0.9592	Exhibit D
5)	x Morbidity Changes		1.1426	Exhibit D
6)	x Trend Factor		1.2387	Exhibit D
7)	x Other Cost of Care Impacts		1.1483	Exhibit D
8)	= Projected Claim Cost	$	434.85	= (3) x (4) x (5) x (6) x (7)
9)	+ Other Claim Adjustments	$	(4.67)	Exhibit E
10)	= Claims Projected to Projection Period	$	430.18	= (8) + (9)
11)	+ Risk Adjustment and Reinsurance - Contributions and Payments	$	(30.55)	Exhibit F
12)	+ Non-Benefit Expenses and Profit & Risk {1}	$	94.92	Exhibit G
13)	= Required Premium in Projection Period	$	494.55	= (10) + (11) + (12)
14)	÷ Calibration Factor		1.7079	Exhibit H
15)	÷ Tobacco Average Rating Factor		1.0336	Exhibit H
16)	= Required Base Rate (Average Plan Level - Age 21 - Non-Tobacco)	$	280.15	= (13) ÷ (14) ÷ (15)
17)	Projected Loss Ratio (Conventional Basis)		80.8%	= [(10) + (11)] ÷ (13)

NOTES:

{1} Equivalent to PMPM expenses on Exhibit G + % of premium expenses on Exhibit G applied to Required Premium (Row 13 above).

Exhibit B - Claims Experience for Manual Rate Development

Anthem Insurance Companies, Inc.
Individual

Incurred January 1, 2013 through December 31, 2013
Paid through March 31, 2014

PAID CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
$ 300,084,409	$ 68,767,025	$ 33,448,874	$ 2,924,264	$ 333,533,283	$ 71,691,289	$ -	$ 405,224,572	1,469,749	**$**	**275.71**

ALLOWED CLAIMS:										
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total	
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM	
$ 405,828,921	$ 96,626,885	$ 43,446,118	$ 3,879,731	$ 449,275,039	$ 100,506,616	$ -	$ 549,781,655	1,469,749	**$**	**374.06**

Exhibit C - Normalization Factors

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

	Average Claim Factors		
	Experience Period Population	Future Population	Normalization Factor
Age/Gender	0.9660	1.2508	1.2948
Area/Network	1.0064	0.9064	0.9006
Benefit Plan	0.7495	0.6502	0.8676
Total			**1.0117**

Exhibit D - Projection Period Adjustments

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Impact of Changes Between Experience Period and Projection Period:		
		Adjustment Factor
Benefit changes		
	Preventive Rx (over the counter)	1.0001
	Rx Adjustments {1}	0.9591
	Total Benefit Changes	0.9592
Morbidity changes		
	Total Morbidity Changes	1.1426
Cost of care impacts		
	Annual Medical/Rx Trend Rate	11.30%
	# Months of Projection	24
	Trend Factor	1.2387
	Medicaid Spend Down	1.0880
	PDD Adjustment	1.0280
	Induced Demand for CSR	1.0267
	Total other Impacts	1.1484

NOTES:

{1} Includes Rx formulary and impacts for moving drugs into different tiers

Exhibit E - Other Claim Adjustments

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Adjustments to projection period claims to reflect covered benefits not included in experience period data:	
	PMPM
Rx Rebates	($5.97)
Pediatric Dental	$0.58
Pediatric Vision	$0.72
Total	($4.67)

NOTES:

Adjustments above reflect ONLY additional costs beyond those already captured in line Item 8 of Exhibit A.

Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Risk Adjustment:

PMPM	User Fee	Net Transfer
Federal Program	$0.08	$0.00

Note:

It is assumed the risk for the plans included in this rate filing is no better/worse than any other plans within this market.

Reinsurance:

PMPM	Contributions Made	Expected Receipts	
Federal Program	$3.67	($34.30)	*Small Group Plans contribute funds but only Individual Plans are eligible to receive payments*

Source:

HHS estimates a national per capita contribution rate of $3.67 per month ($44 per year) in benefit year 2015 (per Payment Parameter Rule).

Grand Total of All Risk Mitigation Programs	($30.55)

Exhibit G - Non-Benefit Expenses and Profit & Risk

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

	Expenses Applied As a PMPM Cost	Expenses Applied as a % of Premium	Expressed as a PMPM {1}
Administrative Expenses			
Administrative Costs	$27.55		
Quality Improvement Expense	$3.98		
Selling Expense	$5.99		
Selling Expense		0.00%	
Specialty Expenses	$0.20		
Total Administrative Expenses	**$37.72**	**0.00%**	$37.72
Taxes and Fees			
PCORI Fee	$0.18		
ACA Insurer Fee		3.79%	
Exchange Fee		2.61%	
Premium Tax		0.00%	
MLR-Deductible Federal/State Income Taxes {2}		1.94%	
Total Taxes and Fees	**$0.18**	**8.34%**	$41.43
Profit and Risk {3}		3.19%	$15.78
Total Non-Benefit Expenses, Profit, and Risk	**$37.90**	**11.53%**	**$94.92**

NOTES:

{1} The sum of the rounded percentages shown may not equal the total at the bottom of the table due to rounding.

{2} Includes only those income taxes which are deductible from the MLR denominator; in particular, Federal income taxes on investment income are excluded.

{3} Profit shown here is post-tax profit, net of those federal and state income taxes which are deductible from the MLR denominator.

Exhibit H - Calibration

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Average 2015 rating factors for 2015 population:	
	Average Rating Factor
Tobacco	1.0336
	Calibration Factors
Age	1.7079
Area	1.0000
Benefit Plan	1.0000
Total Calibration Factor	1.7079
Total Average Rating Factor	1.7653

NOTES:

See Line Item 14 on Exhibit A.

The base rate is developed by dividing the required premium in the projection period by the total average rating factor shown above.

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Catastrophic DirectAccess	17575IN0700029	On/Off	Catastrophic	0.6429	IN IND:-:Pathway X HMO/POS	All	17575IN0700014	6.13%
Anthem Bronze DirectAccess w/HSA caar	17575IN0700024	On/Off	Bronze	0.7962	IN IND:-:Pathway X HMO/POS	All	17575IN0700004	11.27%
Anthem Bronze DirectAccess caae	17575IN0700023	On/Off	Bronze	0.8510	IN IND:-:Pathway X HMO/POS	All	17575IN0700003	9.88%
Anthem Bronze DirectAccess caaa	17575IN0700020	On/Off	Bronze	0.8601	IN IND:-:Pathway X HMO/POS	All	17575IN0700001	9.79%
Anthem Bronze DirectAccess w/HSA cabm	17575IN0700025	On/Off	Bronze	0.7979	IN IND:-:Pathway X HMO/POS	All	17575IN0700005	10.41%
Anthem Bronze DirectAccess cabr	17575IN0700021	On/Off	Bronze	0.8609	IN IND:-:Pathway X HMO/POS	All	17575IN0700002	16.63%
Anthem Silver DirectAccess cbaa	17575IN0700026	On/Off	Silver	1.0708	IN IND:-:Pathway X HMO/POS	All	17575IN0700008	11.38%
Anthem Silver DirectAccess w/HSA cbbg	17575IN0700028	On/Off	Silver	0.9872	IN IND:-:Pathway X HMO/POS	All	17575IN0700011	11.43%
Anthem Silver DirectAccess cbds	17575IN0700027	On/Off	Silver	1.0655	IN IND:-:Pathway X HMO/POS	All	17575IN0700010	15.18%
Anthem Bronze DirectAccess caca	17575IN0760002	On/Off	Bronze	0.8091	IN IND:-:Pathway X HMO/POS	All	17575IN0760001	13.95%
Anthem Bronze Pathway 5750/20%	17575IN0770017	Off	Bronze	0.9367	IN IND:-:Pathway HMO/POS	1	17575IN0770003	10.41%
Anthem Bronze Pathway 5750/20%	17575IN0770041	Off	Bronze	0.9515	IN IND:-:Pathway HMO/POS	2	17575IN0770003	11.46%
Anthem Bronze Pathway 5750/20%	17575IN0770042	Off	Bronze	0.9558	IN IND:-:Pathway HMO/POS	3	17575IN0770003	5.71%
Anthem Bronze Pathway 5750/20%	17575IN0770043	Off	Bronze	0.9566	IN IND:-:Pathway HMO/POS	4	17575IN0770003	14.26%
Anthem Bronze Pathway 5750/20%	17575IN0770044	Off	Bronze	0.9353	IN IND:-:Pathway HMO/POS	5	17575IN0770003	15.21%
Anthem Bronze Pathway 5750/20%	17575IN0770045	Off	Bronze	0.9391	IN IND:-:Pathway HMO/POS	6	17575IN0770003	11.76%
Anthem Bronze Pathway 5750/20%	17575IN0770046	Off	Bronze	0.9360	IN IND:-:Pathway HMO/POS	7	17575IN0770003	8.74%
Anthem Bronze Pathway 5750/20%	17575IN0770047	Off	Bronze	0.9360	IN IND:-:Pathway HMO/POS	8	17575IN0770003	3.59%
Anthem Bronze Pathway 5750/20%	17575IN0770048	Off	Bronze	0.9361	IN IND:-:Pathway HMO/POS	9	17575IN0770003	9.53%
Anthem Bronze Pathway 5750/20%	17575IN0770049	Off	Bronze	0.9340	IN IND:-:Pathway HMO/POS	10	17575IN0770003	5.92%
Anthem Bronze Pathway 5750/20%	17575IN0770050	Off	Bronze	0.9337	IN IND:-:Pathway HMO/POS	11	17575IN0770003	7.20%
Anthem Bronze Pathway 5750/20%	17575IN0770051	Off	Bronze	0.9287	IN IND:-:Pathway HMO/POS	12	17575IN0770003	16.01%
Anthem Bronze Pathway 5750/20%	17575IN0770052	Off	Bronze	0.9220	IN IND:-:Pathway HMO/POS	13	17575IN0770003	7.90%
Anthem Bronze Pathway 5750/20%	17575IN0770053	Off	Bronze	0.9006	IN IND:-:Pathway HMO/POS	14	17575IN0770003	1.73%
Anthem Bronze Pathway 5750/20%	17575IN0770054	Off	Bronze	0.9250	IN IND:-:Pathway HMO/POS	15	17575IN0770003	2.83%
Anthem Bronze Pathway 5750/20%	17575IN0770055	Off	Bronze	0.8715	IN IND:-:Pathway HMO/POS	16	17575IN0770003	4.30%
Anthem Bronze Pathway 5750/20%	17575IN0770056	Off	Bronze	0.9333	IN IND:-:Pathway HMO/POS	17	17575IN0770003	8.89%
Anthem Bronze Pathway 6000/30%	17575IN0770018	Off	Bronze	0.8815	IN IND:-:Pathway HMO/POS	1	17575IN0770005	4.67%
Anthem Bronze Pathway 6000/30%	17575IN0770057	Off	Bronze	0.8955	IN IND:-:Pathway HMO/POS	2	17575IN0770005	5.65%
Anthem Bronze Pathway 6000/30%	17575IN0770058	Off	Bronze	0.8995	IN IND:-:Pathway HMO/POS	3	17575IN0770005	0.21%
Anthem Bronze Pathway 6000/30%	17575IN0770059	Off	Bronze	0.9003	IN IND:-:Pathway HMO/POS	4	17575IN0770005	8.31%
Anthem Bronze Pathway 6000/30%	17575IN0770060	Off	Bronze	0.8803	IN IND:-:Pathway HMO/POS	5	17575IN0770005	9.21%
Anthem Bronze Pathway 6000/30%	17575IN0770061	Off	Bronze	0.8839	IN IND:-:Pathway HMO/POS	6	17575IN0770005	5.94%
Anthem Bronze Pathway 6000/30%	17575IN0770062	Off	Bronze	0.8809	IN IND:-:Pathway HMO/POS	7	17575IN0770005	3.07%
Anthem Bronze Pathway 6000/30%	17575IN0770063	Off	Bronze	0.8809	IN IND:-:Pathway HMO/POS	8	17575IN0770005	-1.80%
Anthem Bronze Pathway 6000/30%	17575IN0770064	Off	Bronze	0.8810	IN IND:-:Pathway HMO/POS	9	17575IN0770005	3.83%
Anthem Bronze Pathway 6000/30%	17575IN0770065	Off	Bronze	0.8790	IN IND:-:Pathway HMO/POS	10	17575IN0770005	0.40%
Anthem Bronze Pathway 6000/30%	17575IN0770066	Off	Bronze	0.8787	IN IND:-:Pathway HMO/POS	11	17575IN0770005	1.62%
Anthem Bronze Pathway 6000/30%	17575IN0770067	Off	Bronze	0.8741	IN IND:-:Pathway HMO/POS	12	17575IN0770005	9.97%
Anthem Bronze Pathway 6000/30%	17575IN0770068	Off	Bronze	0.8677	IN IND:-:Pathway HMO/POS	13	17575IN0770005	2.29%
Anthem Bronze Pathway 6000/30%	17575IN0770069	Off	Bronze	0.8476	IN IND:-:Pathway HMO/POS	14	17575IN0770005	-3.57%
Anthem Bronze Pathway 6000/30%	17575IN0770070	Off	Bronze	0.8705	IN IND:-:Pathway HMO/POS	15	17575IN0770005	-2.53%
Anthem Bronze Pathway 6000/30%	17575IN0770071	Off	Bronze	0.8202	IN IND:-:Pathway HMO/POS	16	17575IN0770005	-1.13%

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Bronze Pathway 6000/30%	17575IN0770072	Off	Bronze	0.8783	IN IND:-:Pathway HMO/POS	17	17575IN0770005	3.22%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770015	Off	Bronze	0.8736	IN IND:-:Pathway HMO/POS	1	17575IN0770001	11.13%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770073	Off	Bronze	0.8874	IN IND:-:Pathway HMO/POS	2	17575IN0770001	12.18%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770074	Off	Bronze	0.8914	IN IND:-:Pathway HMO/POS	3	17575IN0770001	6.40%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770075	Off	Bronze	0.8922	IN IND:-:Pathway HMO/POS	4	17575IN0770001	15.01%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770076	Off	Bronze	0.8723	IN IND:-:Pathway HMO/POS	5	17575IN0770001	15.96%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770077	Off	Bronze	0.8759	IN IND:-:Pathway HMO/POS	6	17575IN0770001	12.49%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770078	Off	Bronze	0.8729	IN IND:-:Pathway HMO/POS	7	17575IN0770001	9.44%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770079	Off	Bronze	0.8730	IN IND:-:Pathway HMO/POS	8	17575IN0770001	4.26%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770080	Off	Bronze	0.8730	IN IND:-:Pathway HMO/POS	9	17575IN0770001	10.24%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770081	Off	Bronze	0.8710	IN IND:-:Pathway HMO/POS	10	17575IN0770001	6.61%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770082	Off	Bronze	0.8708	IN IND:-:Pathway HMO/POS	11	17575IN0770001	7.90%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770083	Off	Bronze	0.8662	IN IND:-:Pathway HMO/POS	12	17575IN0770001	16.77%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770084	Off	Bronze	0.8599	IN IND:-:Pathway HMO/POS	13	17575IN0770001	8.61%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770085	Off	Bronze	0.8400	IN IND:-:Pathway HMO/POS	14	17575IN0770001	2.39%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770086	Off	Bronze	0.8627	IN IND:-:Pathway HMO/POS	15	17575IN0770001	3.50%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770087	Off	Bronze	0.8128	IN IND:-:Pathway HMO/POS	16	17575IN0770001	4.98%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770088	Off	Bronze	0.8704	IN IND:-:Pathway HMO/POS	17	17575IN0770001	9.60%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770016	Off	Bronze	0.8980	IN IND:-:Pathway HMO/POS	1	17575IN0770002	11.19%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770089	Off	Bronze	0.9122	IN IND:-:Pathway HMO/POS	2	17575IN0770002	12.24%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770090	Off	Bronze	0.9163	IN IND:-:Pathway HMO/POS	3	17575IN0770002	6.45%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770091	Off	Bronze	0.9171	IN IND:-:Pathway HMO/POS	4	17575IN0770002	15.06%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770092	Off	Bronze	0.8967	IN IND:-:Pathway HMO/POS	5	17575IN0770002	16.01%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770093	Off	Bronze	0.9004	IN IND:-:Pathway HMO/POS	6	17575IN0770002	12.54%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770094	Off	Bronze	0.8973	IN IND:-:Pathway HMO/POS	7	17575IN0770002	9.50%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770095	Off	Bronze	0.8974	IN IND:-:Pathway HMO/POS	8	17575IN0770002	4.31%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770096	Off	Bronze	0.8974	IN IND:-:Pathway HMO/POS	9	17575IN0770002	10.29%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770097	Off	Bronze	0.8954	IN IND:-:Pathway HMO/POS	10	17575IN0770002	6.66%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770098	Off	Bronze	0.8951	IN IND:-:Pathway HMO/POS	11	17575IN0770002	7.95%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770099	Off	Bronze	0.8904	IN IND:-:Pathway HMO/POS	12	17575IN0770002	16.82%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770100	Off	Bronze	0.8839	IN IND:-:Pathway HMO/POS	13	17575IN0770002	8.66%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770101	Off	Bronze	0.8635	IN IND:-:Pathway HMO/POS	14	17575IN0770002	2.44%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770102	Off	Bronze	0.8868	IN IND:-:Pathway HMO/POS	15	17575IN0770002	3.55%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770103	Off	Bronze	0.8356	IN IND:-:Pathway HMO/POS	16	17575IN0770002	5.03%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770104	Off	Bronze	0.8947	IN IND:-:Pathway HMO/POS	17	17575IN0770002	9.65%
Anthem Silver Pathway 2850/15%	17575IN0770022	Off	Silver	1.1051	IN IND:-:Pathway HMO/POS	1	17575IN0770009	11.81%
Anthem Silver Pathway 2850/15%	17575IN0770105	Off	Silver	1.1226	IN IND:-:Pathway HMO/POS	2	17575IN0770009	12.86%
Anthem Silver Pathway 2850/15%	17575IN0770106	Off	Silver	1.1277	IN IND:-:Pathway HMO/POS	3	17575IN0770009	7.05%
Anthem Silver Pathway 2850/15%	17575IN0770107	Off	Silver	1.1287	IN IND:-:Pathway HMO/POS	4	17575IN0770009	15.71%
Anthem Silver Pathway 2850/15%	17575IN0770108	Off	Silver	1.1035	IN IND:-:Pathway HMO/POS	5	17575IN0770009	16.66%
Anthem Silver Pathway 2850/15%	17575IN0770109	Off	Silver	1.1081	IN IND:-:Pathway HMO/POS	6	17575IN0770009	13.17%
Anthem Silver Pathway 2850/15%	17575IN0770110	Off	Silver	1.1043	IN IND:-:Pathway HMO/POS	7	17575IN0770009	10.11%
Anthem Silver Pathway 2850/15%	17575IN0770111	Off	Silver	1.1044	IN IND:-:Pathway HMO/POS	8	17575IN0770009	4.90%

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Silver Pathway 2850/15%	17575IN0770112	Off	Silver	1.1044	IN IND:-:Pathway HMO/POS	9	17575IN0770009	10.91%
Anthem Silver Pathway 2850/15%	17575IN0770113	Off	Silver	1.1019	IN IND:-:Pathway HMO/POS	10	17575IN0770009	7.25%
Anthem Silver Pathway 2850/15%	17575IN0770114	Off	Silver	1.1016	IN IND:-:Pathway HMO/POS	11	17575IN0770009	8.55%
Anthem Silver Pathway 2850/15%	17575IN0770115	Off	Silver	1.0958	IN IND:-:Pathway HMO/POS	12	17575IN0770009	17.48%
Anthem Silver Pathway 2850/15%	17575IN0770116	Off	Silver	1.0878	IN IND:-:Pathway HMO/POS	13	17575IN0770009	9.27%
Anthem Silver Pathway 2850/15%	17575IN0770117	Off	Silver	1.0626	IN IND:-:Pathway HMO/POS	14	17575IN0770009	3.01%
Anthem Silver Pathway 2850/15%	17575IN0770118	Off	Silver	1.0914	IN IND:-:Pathway HMO/POS	15	17575IN0770009	4.13%
Anthem Silver Pathway 2850/15%	17575IN0770119	Off	Silver	1.0283	IN IND:-:Pathway HMO/POS	16	17575IN0770009	5.62%
Anthem Silver Pathway 2850/15%	17575IN0770120	Off	Silver	1.1011	IN IND:-:Pathway HMO/POS	17	17575IN0770009	10.27%
Anthem Silver Pathway 2500/10%	17575IN0770019	Off	Silver	1.1663	IN IND:-:Pathway HMO/POS	1	17575IN0770006	12.57%
Anthem Silver Pathway 2500/10%	17575IN0770121	Off	Silver	1.1848	IN IND:-:Pathway HMO/POS	2	17575IN0770006	13.63%
Anthem Silver Pathway 2500/10%	17575IN0770122	Off	Silver	1.1901	IN IND:-:Pathway HMO/POS	3	17575IN0770006	7.78%
Anthem Silver Pathway 2500/10%	17575IN0770123	Off	Silver	1.1911	IN IND:-:Pathway HMO/POS	4	17575IN0770006	16.49%
Anthem Silver Pathway 2500/10%	17575IN0770124	Off	Silver	1.1646	IN IND:-:Pathway HMO/POS	5	17575IN0770006	17.45%
Anthem Silver Pathway 2500/10%	17575IN0770125	Off	Silver	1.1694	IN IND:-:Pathway HMO/POS	6	17575IN0770006	13.94%
Anthem Silver Pathway 2500/10%	17575IN0770126	Off	Silver	1.1654	IN IND:-:Pathway HMO/POS	7	17575IN0770006	10.86%
Anthem Silver Pathway 2500/10%	17575IN0770127	Off	Silver	1.1655	IN IND:-:Pathway HMO/POS	8	17575IN0770006	5.61%
Anthem Silver Pathway 2500/10%	17575IN0770128	Off	Silver	1.1655	IN IND:-:Pathway HMO/POS	9	17575IN0770006	11.67%
Anthem Silver Pathway 2500/10%	17575IN0770129	Off	Silver	1.1629	IN IND:-:Pathway HMO/POS	10	17575IN0770006	7.98%
Anthem Silver Pathway 2500/10%	17575IN0770130	Off	Silver	1.1626	IN IND:-:Pathway HMO/POS	11	17575IN0770006	9.29%
Anthem Silver Pathway 2500/10%	17575IN0770131	Off	Silver	1.1564	IN IND:-:Pathway HMO/POS	12	17575IN0770006	18.28%
Anthem Silver Pathway 2500/10%	17575IN0770132	Off	Silver	1.1480	IN IND:-:Pathway HMO/POS	13	17575IN0770006	10.01%
Anthem Silver Pathway 2500/10%	17575IN0770133	Off	Silver	1.1214	IN IND:-:Pathway HMO/POS	14	17575IN0770006	3.71%
Anthem Silver Pathway 2500/10%	17575IN0770134	Off	Silver	1.1518	IN IND:-:Pathway HMO/POS	15	17575IN0770006	4.83%
Anthem Silver Pathway 2500/10%	17575IN0770135	Off	Silver	1.0852	IN IND:-:Pathway HMO/POS	16	17575IN0770006	6.33%
Anthem Silver Pathway 2500/10%	17575IN0770136	Off	Silver	1.1620	IN IND:-:Pathway HMO/POS	17	17575IN0770006	11.02%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770020	Off	Silver	1.1196	IN IND:-:Pathway HMO/POS	1	17575IN0770007	13.87%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770137	Off	Silver	1.1374	IN IND:-:Pathway HMO/POS	2	17575IN0770007	14.94%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770138	Off	Silver	1.1425	IN IND:-:Pathway HMO/POS	3	17575IN0770007	9.02%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770139	Off	Silver	1.1435	IN IND:-:Pathway HMO/POS	4	17575IN0770007	17.84%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770140	Off	Silver	1.1180	IN IND:-:Pathway HMO/POS	5	17575IN0770007	18.81%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770141	Off	Silver	1.1226	IN IND:-:Pathway HMO/POS	6	17575IN0770007	15.26%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770142	Off	Silver	1.1188	IN IND:-:Pathway HMO/POS	7	17575IN0770007	12.14%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770143	Off	Silver	1.1189	IN IND:-:Pathway HMO/POS	8	17575IN0770007	6.83%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770144	Off	Silver	1.1189	IN IND:-:Pathway HMO/POS	9	17575IN0770007	12.95%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770145	Off	Silver	1.1164	IN IND:-:Pathway HMO/POS	10	17575IN0770007	9.23%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770146	Off	Silver	1.1161	IN IND:-:Pathway HMO/POS	11	17575IN0770007	10.55%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770147	Off	Silver	1.1102	IN IND:-:Pathway HMO/POS	12	17575IN0770007	19.64%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770148	Off	Silver	1.1020	IN IND:-:Pathway HMO/POS	13	17575IN0770007	11.28%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770149	Off	Silver	1.0766	IN IND:-:Pathway HMO/POS	14	17575IN0770007	4.91%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770150	Off	Silver	1.1057	IN IND:-:Pathway HMO/POS	15	17575IN0770007	6.04%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770151	Off	Silver	1.0418	IN IND:-:Pathway HMO/POS	16	17575IN0770007	7.56%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770152	Off	Silver	1.1155	IN IND:-:Pathway HMO/POS	17	17575IN0770007	12.30%

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Silver Pathway 1750/20%	17575IN0770021	Off	Silver	1.1583	IN IND:-:Pathway HMO/POS	1	17575IN0770008	12.33%
Anthem Silver Pathway 1750/20%	17575IN0770153	Off	Silver	1.1766	IN IND:-:Pathway HMO/POS	2	17575IN0770008	13.40%
Anthem Silver Pathway 1750/20%	17575IN0770154	Off	Silver	1.1819	IN IND:-:Pathway HMO/POS	3	17575IN0770008	7.55%
Anthem Silver Pathway 1750/20%	17575IN0770155	Off	Silver	1.1829	IN IND:-:Pathway HMO/POS	4	17575IN0770008	16.25%
Anthem Silver Pathway 1750/20%	17575IN0770156	Off	Silver	1.1566	IN IND:-:Pathway HMO/POS	5	17575IN0770008	17.21%
Anthem Silver Pathway 1750/20%	17575IN0770157	Off	Silver	1.1613	IN IND:-:Pathway HMO/POS	6	17575IN0770008	13.71%
Anthem Silver Pathway 1750/20%	17575IN0770158	Off	Silver	1.1574	IN IND:-:Pathway HMO/POS	7	17575IN0770008	10.63%
Anthem Silver Pathway 1750/20%	17575IN0770159	Off	Silver	1.1575	IN IND:-:Pathway HMO/POS	8	17575IN0770008	5.39%
Anthem Silver Pathway 1750/20%	17575IN0770160	Off	Silver	1.1575	IN IND:-:Pathway HMO/POS	9	17575IN0770008	11.43%
Anthem Silver Pathway 1750/20%	17575IN0770161	Off	Silver	1.1549	IN IND:-:Pathway HMO/POS	10	17575IN0770008	7.76%
Anthem Silver Pathway 1750/20%	17575IN0770162	Off	Silver	1.1546	IN IND:-:Pathway HMO/POS	11	17575IN0770008	9.06%
Anthem Silver Pathway 1750/20%	17575IN0770163	Off	Silver	1.1484	IN IND:-:Pathway HMO/POS	12	17575IN0770008	18.03%
Anthem Silver Pathway 1750/20%	17575IN0770164	Off	Silver	1.1401	IN IND:-:Pathway HMO/POS	13	17575IN0770008	9.78%
Anthem Silver Pathway 1750/20%	17575IN0770165	Off	Silver	1.1137	IN IND:-:Pathway HMO/POS	14	17575IN0770008	3.50%
Anthem Silver Pathway 1750/20%	17575IN0770166	Off	Silver	1.1438	IN IND:-:Pathway HMO/POS	15	17575IN0770008	4.62%
Anthem Silver Pathway 1750/20%	17575IN0770167	Off	Silver	1.0777	IN IND:-:Pathway HMO/POS	16	17575IN0770008	6.11%
Anthem Silver Pathway 1750/20%	17575IN0770168	Off	Silver	1.1540	IN IND:-:Pathway HMO/POS	17	17575IN0770008	10.78%
Anthem Gold Pathway 1250/10%	17575IN0770023	Off	Gold	1.3092	IN IND:-:Pathway HMO/POS	1	17575IN0770010	8.87%
Anthem Gold Pathway 1250/10%	17575IN0770169	Off	Gold	1.3300	IN IND:-:Pathway HMO/POS	2	17575IN0770010	9.90%
Anthem Gold Pathway 1250/10%	17575IN0770170	Off	Gold	1.3360	IN IND:-:Pathway HMO/POS	3	17575IN0770010	4.23%
Anthem Gold Pathway 1250/10%	17575IN0770171	Off	Gold	1.3371	IN IND:-:Pathway HMO/POS	4	17575IN0770010	12.66%
Anthem Gold Pathway 1250/10%	17575IN0770172	Off	Gold	1.3073	IN IND:-:Pathway HMO/POS	5	17575IN0770010	13.59%
Anthem Gold Pathway 1250/10%	17575IN0770173	Off	Gold	1.3127	IN IND:-:Pathway HMO/POS	6	17575IN0770010	10.20%
Anthem Gold Pathway 1250/10%	17575IN0770174	Off	Gold	1.3082	IN IND:-:Pathway HMO/POS	7	17575IN0770010	7.21%
Anthem Gold Pathway 1250/10%	17575IN0770175	Off	Gold	1.3083	IN IND:-:Pathway HMO/POS	8	17575IN0770010	2.14%
Anthem Gold Pathway 1250/10%	17575IN0770176	Off	Gold	1.3084	IN IND:-:Pathway HMO/POS	9	17575IN0770010	8.00%
Anthem Gold Pathway 1250/10%	17575IN0770177	Off	Gold	1.3055	IN IND:-:Pathway HMO/POS	10	17575IN0770010	4.43%
Anthem Gold Pathway 1250/10%	17575IN0770178	Off	Gold	1.3051	IN IND:-:Pathway HMO/POS	11	17575IN0770010	5.70%
Anthem Gold Pathway 1250/10%	17575IN0770179	Off	Gold	1.2982	IN IND:-:Pathway HMO/POS	12	17575IN0770010	14.39%
Anthem Gold Pathway 1250/10%	17575IN0770180	Off	Gold	1.2887	IN IND:-:Pathway HMO/POS	13	17575IN0770010	6.39%
Anthem Gold Pathway 1250/10%	17575IN0770181	Off	Gold	1.2589	IN IND:-:Pathway HMO/POS	14	17575IN0770010	0.30%
Anthem Gold Pathway 1250/10%	17575IN0770182	Off	Gold	1.2929	IN IND:-:Pathway HMO/POS	15	17575IN0770010	1.39%
Anthem Gold Pathway 1250/10%	17575IN0770183	Off	Gold	1.2182	IN IND:-:Pathway HMO/POS	16	17575IN0770010	2.84%
Anthem Gold Pathway 1250/10%	17575IN0770184	Off	Gold	1.3045	IN IND:-:Pathway HMO/POS	17	17575IN0770010	7.37%
Anthem Bronze Pathway POS 5000/40%	17575IN0780005	Off	Bronze	0.8809	IN IND:-:Pathway HMO/POS	1	17575IN0780001	13.67%
Anthem Bronze Pathway POS 5000/40%	17575IN0780006	Off	Bronze	0.8949	IN IND:-:Pathway HMO/POS	2	17575IN0780001	14.75%
Anthem Bronze Pathway POS 5000/40%	17575IN0780007	Off	Bronze	0.8989	IN IND:-:Pathway HMO/POS	3	17575IN0780001	8.83%
Anthem Bronze Pathway POS 5000/40%	17575IN0780008	Off	Bronze	0.8997	IN IND:-:Pathway HMO/POS	4	17575IN0780001	17.64%
Anthem Bronze Pathway POS 5000/40%	17575IN0780009	Off	Bronze	0.8796	IN IND:-:Pathway HMO/POS	5	17575IN0780001	18.61%
Anthem Bronze Pathway POS 5000/40%	17575IN0780010	Off	Bronze	0.8832	IN IND:-:Pathway HMO/POS	6	17575IN0780001	15.06%
Anthem Bronze Pathway POS 5000/40%	17575IN0780011	Off	Bronze	0.8802	IN IND:-:Pathway HMO/POS	7	17575IN0780001	11.95%
Anthem Bronze Pathway POS 5000/40%	17575IN0780012	Off	Bronze	0.8803	IN IND:-:Pathway HMO/POS	8	17575IN0780001	6.65%
Anthem Bronze Pathway POS 5000/40%	17575IN0780013	Off	Bronze	0.8803	IN IND:-:Pathway HMO/POS	9	17575IN0780001	12.76%

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Bronze Pathway POS 5000/40%	17575IN0780014	Off	Bronze	0.8784	IN IND:-:Pathway HMO/POS	10	17575IN0780001	9.04%
Anthem Bronze Pathway POS 5000/40%	17575IN0780015	Off	Bronze	0.8781	IN IND:-:Pathway HMO/POS	11	17575IN0780001	10.36%
Anthem Bronze Pathway POS 5000/40%	17575IN0780016	Off	Bronze	0.8735	IN IND:-:Pathway HMO/POS	12	17575IN0780001	19.44%
Anthem Bronze Pathway POS 5000/40%	17575IN0780017	Off	Bronze	0.8671	IN IND:-:Pathway HMO/POS	13	17575IN0780001	11.09%
Anthem Bronze Pathway POS 5000/40%	17575IN0780018	Off	Bronze	0.8470	IN IND:-:Pathway HMO/POS	14	17575IN0780001	4.73%
Anthem Bronze Pathway POS 5000/40%	17575IN0780019	Off	Bronze	0.8699	IN IND:-:Pathway HMO/POS	15	17575IN0780001	5.86%
Anthem Bronze Pathway POS 5000/40%	17575IN0780020	Off	Bronze	0.8197	IN IND:-:Pathway HMO/POS	16	17575IN0780001	7.38%
Anthem Bronze Pathway POS 5000/40%	17575IN0780021	Off	Bronze	0.8777	IN IND:-:Pathway HMO/POS	17	17575IN0780001	12.11%
Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan	17575IN0930005	On	Silver	1.0478	IN IND:-:Pathway X HMO/POS	All	17575IN0930001	4.47%
Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan	17575IN0930006	On	Gold	1.2217	IN IND:-:Pathway X HMO/POS	All	17575IN0930002	-2.66%

NOTES:

Benefit Plan Factors above reflect plan by plan differences from the index rate for allowable adjustments as described in detail in the Market Reform and Payment Parameters Regulations and illustrated in Exhibit O. The weighted average of these adjustments for the entire risk pool included in this rate filing is detailed in Exhibit H.

Plan level increases in rates do not include demographic changes in the population.

Exhibit J - Age and Tobacco Factors

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Age	Age Rating Factor	Tobacco Rating Factor
0-17	0.635	1.000
18	0.635	1.050
19	0.635	1.050
20	0.635	1.050
21	1.000	1.050
22	1.000	1.050
23	1.000	1.050
24	1.000	1.050
25	1.004	1.100
26	1.024	1.100
27	1.048	1.100
28	1.087	1.100
29	1.119	1.100
30	1.135	1.150
31	1.159	1.150
32	1.183	1.150
33	1.198	1.150
34	1.214	1.150
35	1.222	1.200
36	1.230	1.200
37	1.238	1.200
38	1.246	1.200
39	1.262	1.200
40	1.278	1.250
41	1.302	1.250
42	1.325	1.250
43	1.357	1.250
44	1.397	1.250
45	1.444	1.300
46	1.500	1.300
47	1.563	1.300
48	1.635	1.300
49	1.706	1.300
50	1.786	1.400
51	1.865	1.400
52	1.952	1.400
53	2.040	1.400
54	2.135	1.400
55	2.230	1.490
56	2.333	1.490
57	2.437	1.490
58	2.548	1.490
59	2.603	1.490
60	2.714	1.490
61	2.810	1.490
62	2.873	1.490
63	2.952	1.490
64+	3.000	1.490

NOTES:

{1} The weighted averages of these factors for the entire risk pool included in this rate filing is detailed in Exhibit H.

Exhibit K - Area Factors

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Rating Area Description	Area Rating Factor
Region 1	0.9706
Region 2	0.9827
Region 3	1.0236
Region 4	1.0141
Region 5	0.9609
Region 6	1.0054
Region 7	1.0053
Region 8	0.9845
Region 9	0.9882
Region 10	1.0617
Region 11	1.0148
Region 12	1.0452
Region 13	1.0260
Region 14	0.9731
Region 15	0.9571
Region 16	0.7828
Region 17	1.0147

NOTES:

{1} The weighted average of these factors for the entire risk pool included in this rate filing is detailed in Exhibit H.

Exhibit L - Sample Rate Calculation

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Name: **John Doe**
Effective Date: **1/1/2015**
On/Off Exchange: On/Off
Metal Level: **Bronze**
Plan ID: 17575IN0700024
Rating Area: **Region 1**

Family Members Covered:

	Age	Smoker?
Subscriber	47	N
Spouse	42	N
Child (age 21+)	25	Y
Child #1	20	N
Child #2	16	N

Calculation of Monthly Premium:

Base Rate =	$280.15	Exhibit A
x Benefit Plan Factor	0.7962	Exhibit I
x Area Factor	0.9706	Exhibit K
Base Rate Adjusted for Plan/Area =	$216.50	

Age/Tobacco Factors: Exhibit J

	Age Factor	Tobacco Factor
Subscriber	1.563	1.000
Spouse	1.325	1.000
Child (age 21+)	1.004	1.100
Child #1	0.635	1.000
Child #2	0.635	1.000

Final Monthly Premium PMPM:

	PMPM
Subscriber	$ 338.39
Spouse	$ 286.86
Child (age 21+)	$ 239.10
Child #1	$ 137.48
Child #2	$ 137.48
TOTAL	**$ 1,139.31**

NOTES:

{1} As per the Market Reform Rule, when computing family premiums no more than the three oldest covered children under the age of 21 are taken into account whereas the premiums associated with each child age 21+ are included.

{2} Minor rate variances may occur due to differences in rounding methodology.

Exhibit M - Federal MLR Estimated Calculation

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Numerator:			
Incurred Claims	$	430.18	Exhibit A
+ Quality Improvement Expense	$	3.98	Exhibit G
+ Risk Corridor Contributions	$	-	
+ Risk Adjustment Net Transfer	$	-	Exhibit F
+ Reinsurance Receipts	$	(34.30)	Exhibit F
+ Risk Corridor Receipts	$	-	
+ Reduction to Rx Incurred Claims (ACA MLR)	$	(7.09)	
= *Estimated* Federal MLR Numerator	$	392.77	
Denominator:			
Premiums	$	494.55	Exhibit A
- Federal and State Taxes	$	9.59	Exhibit A (Line 13) x Exhibit G (Income Taxes)
- Premium Taxes	$	-	Exhibit A (Line 13) x Exhibit G (Premium Tax)
- Risk Adjustment User Fee	$	0.08	Exhibit F
- Reinsurance Contributions	$	3.67	Exhibit F
- Licensing and Regulatory Fees	$	31.83	Exhibit A (Line 13) x Exhibit G (Fees)
= *Estimated* Federal MLR Denominator	$	449.38	
***Estimated* Federal MLR**		**87.40%**	

NOTES:

The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

{1} The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.

{2} Not all numerator/denominator components are captured above (for example, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).

{3} Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.

{4} Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule.

Exhibit N - Market Adjusted Index Rate Development

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

1)	Projected Paid Claim Cost	$	434.85	Exhibit A, Line Item 8
2)	- Non-EHBs Embedded in Line Item 1) Above	$	-	
3)	= Projected Paid Claims, Excluding ALL Non-EHBs	$	434.85	
4)	+ Rx Rebates	$	(5.97)	Exhibit E
5)	+ Additional EHBs {1}	$	1.30	Exhibit E
6)	= Projected Paid Claims Reflecting only EHBs	$	430.18	
7)	÷ Paid to Allowed Ratio		0.6854	
8)	= Projected Allowed Claims Reflecting only EHBs	**$**	**627.63**	**= Index Rate**
9)	Reinsurance Contribution	$	3.67	Exhibit F
10)	Expected Reinsurance Payments	$	(34.30)	Exhibit F
11)	Risk Adjustment Fee	$	0.08	Exhibit F
12)	Risk Adjustment Net Transfer	$	-	Exhibit F
13)	Exchange Fee	$	12.91	
14)	**Market Adjusted Index Rate**	$	601.89	= [(6) + (9) + (10) + (11) + (12) + (13)] ÷ (7)

NOTE:

{1} Pediatric Dental and Pediatric Vision

{2} The Market Adjusted Index Rate is the same for all plans in the single risk pool

Exhibit O - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit N)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Consumer Adjusted Premium Rate {4}
Anthem Catastrophic DirectAccess	17575IN0700029	$601.89	0.5701	0.9797	1.0000	0.7586	$52.58	$307.62	1.7079	$180.12
Anthem Bronze DirectAccess w/HSA caar	17575IN0700024	$601.89	0.5349	0.9797	1.0000	1.0015	$65.08	$380.98	1.7079	$223.07
Anthem Bronze DirectAccess caae	17575IN0700023	$601.89	0.5717	0.9797	1.0000	1.0015	$69.55	$407.16	1.7079	$238.40
Anthem Bronze DirectAccess caaa	17575IN0700020	$601.89	0.5778	0.9797	1.0000	1.0015	$70.30	$411.54	1.7079	$240.96
Anthem Bronze DirectAccess w/HSA cabm	17575IN0700025	$601.89	0.5360	0.9797	1.0000	1.0015	$65.24	$381.77	1.7079	$223.53
Anthem Bronze DirectAccess cabr	17575IN0700021	$601.89	0.5783	0.9797	1.0000	1.0015	$70.37	$411.90	1.7079	$241.17
Anthem Silver DirectAccess cbaa	17575IN0700026	$601.89	0.7194	0.9797	1.0000	1.0015	$87.52	$512.36	1.7079	$299.99
Anthem Silver DirectAccess w/HSA cbbg	17575IN0700028	$601.89	0.6632	0.9797	1.0000	1.0015	$80.70	$472.36	1.7079	$276.57
Anthem Silver DirectAccess cbds	17575IN0700027	$601.89	0.7157	0.9797	1.0000	1.0015	$87.10	$509.80	1.7079	$298.49
Anthem Bronze DirectAccess caca	17575IN0760002	$601.89	0.5435	0.9797	1.0000	1.0015	$66.14	$387.12	1.7079	$226.66
Anthem Bronze Pathway 5750/20%	17575IN0770017	$601.89	0.5790	1.0648	1.0000	1.0015	$76.54	$448.17	1.7079	$262.41
Anthem Bronze Pathway 5750/20%	17575IN0770041	$601.89	0.5790	1.0816	1.0000	1.0015	$77.75	$455.27	1.7079	$266.56
Anthem Bronze Pathway 5750/20%	17575IN0770042	$601.89	0.5790	1.0865	1.0000	1.0015	$78.10	$457.32	1.7079	$267.76
Anthem Bronze Pathway 5750/20%	17575IN0770043	$601.89	0.5790	1.0874	1.0000	1.0015	$78.17	$457.71	1.7079	$267.99
Anthem Bronze Pathway 5750/20%	17575IN0770044	$601.89	0.5790	1.0632	1.0000	1.0015	$76.43	$447.52	1.7079	$262.03
Anthem Bronze Pathway 5750/20%	17575IN0770045	$601.89	0.5790	1.0676	1.0000	1.0015	$76.75	$449.36	1.7079	$263.10
Anthem Bronze Pathway 5750/20%	17575IN0770046	$601.89	0.5790	1.0640	1.0000	1.0015	$76.49	$447.83	1.7079	$262.21
Anthem Bronze Pathway 5750/20%	17575IN0770047	$601.89	0.5790	1.0640	1.0000	1.0015	$76.49	$447.86	1.7079	$262.23
Anthem Bronze Pathway 5750/20%	17575IN0770048	$601.89	0.5790	1.0641	1.0000	1.0015	$76.49	$447.88	1.7079	$262.24
Anthem Bronze Pathway 5750/20%	17575IN0770049	$601.89	0.5790	1.0617	1.0000	1.0015	$76.32	$446.87	1.7079	$261.65
Anthem Bronze Pathway 5750/20%	17575IN0770050	$601.89	0.5790	1.0614	1.0000	1.0015	$76.30	$446.74	1.7079	$261.57
Anthem Bronze Pathway 5750/20%	17575IN0770051	$601.89	0.5790	1.0557	1.0000	1.0015	$75.90	$444.38	1.7079	$260.19
Anthem Bronze Pathway 5750/20%	17575IN0770052	$601.89	0.5790	1.0480	1.0000	1.0015	$75.34	$441.13	1.7079	$258.29
Anthem Bronze Pathway 5750/20%	17575IN0770053	$601.89	0.5790	1.0238	1.0000	1.0015	$73.61	$430.93	1.7079	$252.32
Anthem Bronze Pathway 5750/20%	17575IN0770054	$601.89	0.5790	1.0515	1.0000	1.0015	$75.59	$442.59	1.7079	$259.14
Anthem Bronze Pathway 5750/20%	17575IN0770055	$601.89	0.5790	0.9907	1.0000	1.0015	$71.23	$417.01	1.7079	$244.16
Anthem Bronze Pathway 5750/20%	17575IN0770056	$601.89	0.5790	1.0609	1.0000	1.0015	$76.27	$446.54	1.7079	$261.45
Anthem Bronze Pathway 6000/30%	17575IN0770018	$601.89	0.5449	1.0648	1.0000	1.0015	$72.04	$421.79	1.7079	$246.96
Anthem Bronze Pathway 6000/30%	17575IN0770057	$601.89	0.5449	1.0816	1.0000	1.0015	$73.18	$428.47	1.7079	$250.87
Anthem Bronze Pathway 6000/30%	17575IN0770058	$601.89	0.5449	1.0865	1.0000	1.0015	$73.51	$430.40	1.7079	$252.00
Anthem Bronze Pathway 6000/30%	17575IN0770059	$601.89	0.5449	1.0874	1.0000	1.0015	$73.57	$430.76	1.7079	$252.22
Anthem Bronze Pathway 6000/30%	17575IN0770060	$601.89	0.5449	1.0632	1.0000	1.0015	$71.94	$421.18	1.7079	$246.60
Anthem Bronze Pathway 6000/30%	17575IN0770061	$601.89	0.5449	1.0676	1.0000	1.0015	$72.23	$422.90	1.7079	$247.61
Anthem Bronze Pathway 6000/30%	17575IN0770062	$601.89	0.5449	1.0640	1.0000	1.0015	$71.99	$421.47	1.7079	$246.78
Anthem Bronze Pathway 6000/30%	17575IN0770063	$601.89	0.5449	1.0640	1.0000	1.0015	$71.99	$421.50	1.7079	$246.79
Anthem Bronze Pathway 6000/30%	17575IN0770064	$601.89	0.5449	1.0641	1.0000	1.0015	$71.99	$421.51	1.7079	$246.80
Anthem Bronze Pathway 6000/30%	17575IN0770065	$601.89	0.5449	1.0617	1.0000	1.0015	$71.83	$420.57	1.7079	$246.25
Anthem Bronze Pathway 6000/30%	17575IN0770066	$601.89	0.5449	1.0614	1.0000	1.0015	$71.81	$420.45	1.7079	$246.17
Anthem Bronze Pathway 6000/30%	17575IN0770067	$601.89	0.5449	1.0557	1.0000	1.0015	$71.43	$418.22	1.7079	$244.87
Anthem Bronze Pathway 6000/30%	17575IN0770068	$601.89	0.5449	1.0480	1.0000	1.0015	$70.91	$415.16	1.7079	$243.08
Anthem Bronze Pathway 6000/30%	17575IN0770069	$601.89	0.5449	1.0238	1.0000	1.0015	$69.27	$405.57	1.7079	$237.46
Anthem Bronze Pathway 6000/30%	17575IN0770070	$601.89	0.5449	1.0515	1.0000	1.0015	$71.14	$416.53	1.7079	$243.88
Anthem Bronze Pathway 6000/30%	17575IN0770071	$601.89	0.5449	0.9907	1.0000	1.0015	$67.04	$392.46	1.7079	$229.79
Anthem Bronze Pathway 6000/30%	17575IN0770072	$601.89	0.5449	1.0609	1.0000	1.0015	$71.78	$420.25	1.7079	$246.06
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770015	$601.89	0.5400	1.0648	1.0000	1.0015	$71.39	$417.99	1.7079	$244.73
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770073	$601.89	0.5400	1.0816	1.0000	1.0015	$72.52	$424.60	1.7079	$248.61
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770074	$601.89	0.5400	1.0865	1.0000	1.0015	$72.85	$426.51	1.7079	$249.73
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770075	$601.89	0.5400	1.0874	1.0000	1.0015	$72.91	$426.88	1.7079	$249.94
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770076	$601.89	0.5400	1.0632	1.0000	1.0015	$71.29	$417.38	1.7079	$244.38
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770077	$601.89	0.5400	1.0676	1.0000	1.0015	$71.58	$419.09	1.7079	$245.38
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770078	$601.89	0.5400	1.0640	1.0000	1.0015	$71.34	$417.67	1.7079	$244.55
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770079	$601.89	0.5400	1.0640	1.0000	1.0015	$71.34	$417.70	1.7079	$244.57

Exhibit O - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit N)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Consumer Adjusted Premium Rate {4}
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770080	$601.89	0.5400	1.0641	1.0000	1.0015	$71.34	$417.71	1.7079	$244.57
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770081	$601.89	0.5400	1.0617	1.0000	1.0015	$71.19	$416.77	1.7079	$244.03
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770082	$601.89	0.5400	1.0614	1.0000	1.0015	$71.16	$416.65	1.7079	$243.95
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770083	$601.89	0.5400	1.0557	1.0000	1.0015	$70.79	$414.45	1.7079	$242.66
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770084	$601.89	0.5400	1.0480	1.0000	1.0015	$70.27	$411.42	1.7079	$240.89
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770085	$601.89	0.5400	1.0238	1.0000	1.0015	$68.65	$401.91	1.7079	$235.32
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770086	$601.89	0.5400	1.0515	1.0000	1.0015	$70.50	$412.77	1.7079	$241.68
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770087	$601.89	0.5400	0.9907	1.0000	1.0015	$66.44	$388.92	1.7079	$227.72
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770088	$601.89	0.5400	1.0609	1.0000	1.0015	$71.13	$416.46	1.7079	$243.84
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770016	$601.89	0.5551	1.0648	1.0000	1.0015	$73.41	$429.67	1.7079	$251.58
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770089	$601.89	0.5551	1.0816	1.0000	1.0015	$74.57	$436.47	1.7079	$255.56
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770090	$601.89	0.5551	1.0865	1.0000	1.0015	$74.90	$438.44	1.7079	$256.71
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770091	$601.89	0.5551	1.0874	1.0000	1.0015	$74.97	$438.81	1.7079	$256.93
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770092	$601.89	0.5551	1.0632	1.0000	1.0015	$73.30	$429.05	1.7079	$251.21
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770093	$601.89	0.5551	1.0676	1.0000	1.0015	$73.60	$430.80	1.7079	$252.24
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770094	$601.89	0.5551	1.0640	1.0000	1.0015	$73.35	$429.34	1.7079	$251.39
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770095	$601.89	0.5551	1.0640	1.0000	1.0015	$73.36	$429.38	1.7079	$251.40
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770096	$601.89	0.5551	1.0641	1.0000	1.0015	$73.36	$429.39	1.7079	$251.41
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770097	$601.89	0.5551	1.0617	1.0000	1.0015	$73.20	$428.43	1.7079	$250.85
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770098	$601.89	0.5551	1.0614	1.0000	1.0015	$73.18	$428.30	1.7079	$250.77
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770099	$601.89	0.5551	1.0557	1.0000	1.0015	$72.79	$426.03	1.7079	$249.45
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770100	$601.89	0.5551	1.0480	1.0000	1.0015	$72.26	$422.92	1.7079	$247.62
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770101	$601.89	0.5551	1.0238	1.0000	1.0015	$70.59	$413.14	1.7079	$241.90
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770102	$601.89	0.5551	1.0515	1.0000	1.0015	$72.50	$424.32	1.7079	$248.44
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770103	$601.89	0.5551	0.9907	1.0000	1.0015	$68.32	$399.79	1.7079	$234.08
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770104	$601.89	0.5551	1.0609	1.0000	1.0015	$73.14	$428.10	1.7079	$250.66
Anthem Silver Pathway 2850/15%	17575IN0770022	$601.89	0.6831	1.0648	1.0000	1.0015	$90.32	$528.78	1.7079	$309.61
Anthem Silver Pathway 2850/15%	17575IN0770105	$601.89	0.6831	1.0816	1.0000	1.0015	$91.75	$537.15	1.7079	$314.51
Anthem Silver Pathway 2850/15%	17575IN0770106	$601.89	0.6831	1.0865	1.0000	1.0015	$92.16	$539.57	1.7079	$315.92
Anthem Silver Pathway 2850/15%	17575IN0770107	$601.89	0.6831	1.0874	1.0000	1.0015	$92.24	$540.03	1.7079	$316.19
Anthem Silver Pathway 2850/15%	17575IN0770108	$601.89	0.6831	1.0632	1.0000	1.0015	$90.19	$528.02	1.7079	$309.16
Anthem Silver Pathway 2850/15%	17575IN0770109	$601.89	0.6831	1.0676	1.0000	1.0015	$90.56	$530.18	1.7079	$310.42
Anthem Silver Pathway 2850/15%	17575IN0770110	$601.89	0.6831	1.0640	1.0000	1.0015	$90.25	$528.38	1.7079	$309.37
Anthem Silver Pathway 2850/15%	17575IN0770111	$601.89	0.6831	1.0640	1.0000	1.0015	$90.26	$528.42	1.7079	$309.39
Anthem Silver Pathway 2850/15%	17575IN0770112	$601.89	0.6831	1.0641	1.0000	1.0015	$90.26	$528.43	1.7079	$309.40
Anthem Silver Pathway 2850/15%	17575IN0770113	$601.89	0.6831	1.0617	1.0000	1.0015	$90.06	$527.25	1.7079	$308.71
Anthem Silver Pathway 2850/15%	17575IN0770114	$601.89	0.6831	1.0614	1.0000	1.0015	$90.03	$527.10	1.7079	$308.62
Anthem Silver Pathway 2850/15%	17575IN0770115	$601.89	0.6831	1.0557	1.0000	1.0015	$89.56	$524.31	1.7079	$306.99
Anthem Silver Pathway 2850/15%	17575IN0770116	$601.89	0.6831	1.0480	1.0000	1.0015	$88.91	$520.47	1.7079	$304.74
Anthem Silver Pathway 2850/15%	17575IN0770117	$601.89	0.6831	1.0238	1.0000	1.0015	$86.85	$508.44	1.7079	$297.70
Anthem Silver Pathway 2850/15%	17575IN0770118	$601.89	0.6831	1.0515	1.0000	1.0015	$89.20	$522.19	1.7079	$305.75
Anthem Silver Pathway 2850/15%	17575IN0770119	$601.89	0.6831	0.9907	1.0000	1.0015	$84.05	$492.01	1.7079	$288.08
Anthem Silver Pathway 2850/15%	17575IN0770120	$601.89	0.6831	1.0609	1.0000	1.0015	$89.99	$526.85	1.7079	$308.48
Anthem Silver Pathway 2500/10%	17575IN0770019	$601.89	0.7209	1.0648	1.0000	1.0015	$95.32	$558.04	1.7079	$326.74
Anthem Silver Pathway 2500/10%	17575IN0770121	$601.89	0.7209	1.0816	1.0000	1.0015	$96.83	$566.88	1.7079	$331.91
Anthem Silver Pathway 2500/10%	17575IN0770122	$601.89	0.7209	1.0865	1.0000	1.0015	$97.26	$569.43	1.7079	$333.41
Anthem Silver Pathway 2500/10%	17575IN0770123	$601.89	0.7209	1.0874	1.0000	1.0015	$97.34	$569.91	1.7079	$333.69
Anthem Silver Pathway 2500/10%	17575IN0770124	$601.89	0.7209	1.0632	1.0000	1.0015	$95.18	$557.23	1.7079	$326.26
Anthem Silver Pathway 2500/10%	17575IN0770125	$601.89	0.7209	1.0676	1.0000	1.0015	$95.57	$559.51	1.7079	$327.60
Anthem Silver Pathway 2500/10%	17575IN0770126	$601.89	0.7209	1.0640	1.0000	1.0015	$95.25	$557.62	1.7079	$326.49
Anthem Silver Pathway 2500/10%	17575IN0770127	$601.89	0.7209	1.0640	1.0000	1.0015	$95.25	$557.66	1.7079	$326.51
Anthem Silver Pathway 2500/10%	17575IN0770128	$601.89	0.7209	1.0641	1.0000	1.0015	$95.26	$557.67	1.7079	$326.52

Exhibit O - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit N)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Consumer Adjusted Premium Rate {4}
Anthem Silver Pathway 2500/10%	17575IN0770129	$601.89	0.7209	1.0617	1.0000	1.0015	$95.04	$556.43	1.7079	$325.79
Anthem Silver Pathway 2500/10%	17575IN0770130	$601.89	0.7209	1.0614	1.0000	1.0015	$95.02	$556.26	1.7079	$325.70
Anthem Silver Pathway 2500/10%	17575IN0770131	$601.89	0.7209	1.0557	1.0000	1.0015	$94.51	$553.32	1.7079	$323.97
Anthem Silver Pathway 2500/10%	17575IN0770132	$601.89	0.7209	1.0480	1.0000	1.0015	$93.82	$549.27	1.7079	$321.60
Anthem Silver Pathway 2500/10%	17575IN0770133	$601.89	0.7209	1.0238	1.0000	1.0015	$91.66	$536.58	1.7079	$314.17
Anthem Silver Pathway 2500/10%	17575IN0770134	$601.89	0.7209	1.0515	1.0000	1.0015	$94.13	$551.09	1.7079	$322.67
Anthem Silver Pathway 2500/10%	17575IN0770135	$601.89	0.7209	0.9907	1.0000	1.0015	$88.71	$519.24	1.7079	$304.02
Anthem Silver Pathway 2500/10%	17575IN0770136	$601.89	0.7209	1.0609	1.0000	1.0015	$94.97	$556.00	1.7079	$325.55
Anthem Silver Pathway 2500/10% for HSA	17575IN0770020	$601.89	0.6921	1.0648	1.0000	1.0015	$91.51	$535.72	1.7079	$313.67
Anthem Silver Pathway 2500/10% for HSA	17575IN0770137	$601.89	0.6921	1.0816	1.0000	1.0015	$92.96	$544.20	1.7079	$318.63
Anthem Silver Pathway 2500/10% for HSA	17575IN0770138	$601.89	0.6921	1.0865	1.0000	1.0015	$93.38	$546.65	1.7079	$320.07
Anthem Silver Pathway 2500/10% for HSA	17575IN0770139	$601.89	0.6921	1.0874	1.0000	1.0015	$93.46	$547.11	1.7079	$320.34
Anthem Silver Pathway 2500/10% for HSA	17575IN0770140	$601.89	0.6921	1.0632	1.0000	1.0015	$91.38	$534.94	1.7079	$313.21
Anthem Silver Pathway 2500/10% for HSA	17575IN0770141	$601.89	0.6921	1.0676	1.0000	1.0015	$91.76	$537.13	1.7079	$314.49
Anthem Silver Pathway 2500/10% for HSA	17575IN0770142	$601.89	0.6921	1.0640	1.0000	1.0015	$91.44	$535.31	1.7079	$313.43
Anthem Silver Pathway 2500/10% for HSA	17575IN0770143	$601.89	0.6921	1.0640	1.0000	1.0015	$91.45	$535.35	1.7079	$313.45
Anthem Silver Pathway 2500/10% for HSA	17575IN0770144	$601.89	0.6921	1.0641	1.0000	1.0015	$91.45	$535.36	1.7079	$313.46
Anthem Silver Pathway 2500/10% for HSA	17575IN0770145	$601.89	0.6921	1.0617	1.0000	1.0015	$91.25	$534.17	1.7079	$312.76
Anthem Silver Pathway 2500/10% for HSA	17575IN0770146	$601.89	0.6921	1.0614	1.0000	1.0015	$91.22	$534.01	1.7079	$312.67
Anthem Silver Pathway 2500/10% for HSA	17575IN0770147	$601.89	0.6921	1.0557	1.0000	1.0015	$90.74	$531.18	1.7079	$311.01
Anthem Silver Pathway 2500/10% for HSA	17575IN0770148	$601.89	0.6921	1.0480	1.0000	1.0015	$90.08	$527.30	1.7079	$308.74
Anthem Silver Pathway 2500/10% for HSA	17575IN0770149	$601.89	0.6921	1.0238	1.0000	1.0015	$88.00	$515.11	1.7079	$301.60
Anthem Silver Pathway 2500/10% for HSA	17575IN0770150	$601.89	0.6921	1.0515	1.0000	1.0015	$90.38	$529.04	1.7079	$309.76
Anthem Silver Pathway 2500/10% for HSA	17575IN0770151	$601.89	0.6921	0.9907	1.0000	1.0015	$85.16	$498.47	1.7079	$291.86
Anthem Silver Pathway 2500/10% for HSA	17575IN0770152	$601.89	0.6921	1.0609	1.0000	1.0015	$91.18	$533.76	1.7079	$312.52
Anthem Silver Pathway 1750/20%	17575IN0770021	$601.89	0.7159	1.0648	1.0000	1.0015	$94.68	$554.19	1.7079	$324.49
Anthem Silver Pathway 1750/20%	17575IN0770153	$601.89	0.7159	1.0816	1.0000	1.0015	$96.18	$562.97	1.7079	$329.62
Anthem Silver Pathway 1750/20%	17575IN0770154	$601.89	0.7159	1.0865	1.0000	1.0015	$96.61	$565.50	1.7079	$331.11
Anthem Silver Pathway 1750/20%	17575IN0770155	$601.89	0.7159	1.0874	1.0000	1.0015	$96.69	$565.98	1.7079	$331.39
Anthem Silver Pathway 1750/20%	17575IN0770156	$601.89	0.7159	1.0632	1.0000	1.0015	$94.55	$553.39	1.7079	$324.01
Anthem Silver Pathway 1750/20%	17575IN0770157	$601.89	0.7159	1.0676	1.0000	1.0015	$94.93	$555.65	1.7079	$325.34
Anthem Silver Pathway 1750/20%	17575IN0770158	$601.89	0.7159	1.0640	1.0000	1.0015	$94.61	$553.77	1.7079	$324.24
Anthem Silver Pathway 1750/20%	17575IN0770159	$601.89	0.7159	1.0640	1.0000	1.0015	$94.62	$553.81	1.7079	$324.26
Anthem Silver Pathway 1750/20%	17575IN0770160	$601.89	0.7159	1.0641	1.0000	1.0015	$94.62	$553.82	1.7079	$324.27
Anthem Silver Pathway 1750/20%	17575IN0770161	$601.89	0.7159	1.0617	1.0000	1.0015	$94.41	$552.59	1.7079	$323.55
Anthem Silver Pathway 1750/20%	17575IN0770162	$601.89	0.7159	1.0614	1.0000	1.0015	$94.38	$552.42	1.7079	$323.45
Anthem Silver Pathway 1750/20%	17575IN0770163	$601.89	0.7159	1.0557	1.0000	1.0015	$93.88	$549.50	1.7079	$321.74
Anthem Silver Pathway 1750/20%	17575IN0770164	$601.89	0.7159	1.0480	1.0000	1.0015	$93.20	$545.48	1.7079	$319.39
Anthem Silver Pathway 1750/20%	17575IN0770165	$601.89	0.7159	1.0238	1.0000	1.0015	$91.05	$532.88	1.7079	$312.00
Anthem Silver Pathway 1750/20%	17575IN0770166	$601.89	0.7159	1.0515	1.0000	1.0015	$93.51	$547.28	1.7079	$320.44
Anthem Silver Pathway 1750/20%	17575IN0770167	$601.89	0.7159	0.9907	1.0000	1.0015	$88.11	$515.66	1.7079	$301.92
Anthem Silver Pathway 1750/20%	17575IN0770168	$601.89	0.7159	1.0609	1.0000	1.0015	$94.34	$552.17	1.7079	$323.30
Anthem Gold Pathway 1250/10%	17575IN0770023	$601.89	0.8092	1.0648	1.0000	1.0015	$107.03	$626.44	1.7079	$366.79
Anthem Gold Pathway 1250/10%	17575IN0770169	$601.89	0.8092	1.0816	1.0000	1.0015	$108.72	$636.35	1.7079	$372.59
Anthem Gold Pathway 1250/10%	17575IN0770170	$601.89	0.8092	1.0865	1.0000	1.0015	$109.20	$639.22	1.7079	$374.27
Anthem Gold Pathway 1250/10%	17575IN0770171	$601.89	0.8092	1.0874	1.0000	1.0015	$109.30	$639.76	1.7079	$374.59
Anthem Gold Pathway 1250/10%	17575IN0770172	$601.89	0.8092	1.0632	1.0000	1.0015	$106.87	$625.53	1.7079	$366.25
Anthem Gold Pathway 1250/10%	17575IN0770173	$601.89	0.8092	1.0676	1.0000	1.0015	$107.31	$628.09	1.7079	$367.75
Anthem Gold Pathway 1250/10%	17575IN0770174	$601.89	0.8092	1.0640	1.0000	1.0015	$106.94	$625.96	1.7079	$366.51
Anthem Gold Pathway 1250/10%	17575IN0770175	$601.89	0.8092	1.0640	1.0000	1.0015	$106.95	$626.01	1.7079	$366.53
Anthem Gold Pathway 1250/10%	17575IN0770176	$601.89	0.8092	1.0641	1.0000	1.0015	$106.95	$626.02	1.7079	$366.54
Anthem Gold Pathway 1250/10%	17575IN0770177	$601.89	0.8092	1.0617	1.0000	1.0015	$106.72	$624.62	1.7079	$365.72

Exhibit O - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit N)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Consumer Adjusted Premium Rate {4}
Anthem Gold Pathway 1250/10%	17575IN0770178	$601.89	0.8092	1.0614	1.0000	1.0015	$106.69	$624.44	1.7079	$365.61
Anthem Gold Pathway 1250/10%	17575IN0770179	$601.89	0.8092	1.0557	1.0000	1.0015	$106.12	$621.13	1.7079	$363.68
Anthem Gold Pathway 1250/10%	17575IN0770180	$601.89	0.8092	1.0480	1.0000	1.0015	$105.35	$616.59	1.7079	$361.02
Anthem Gold Pathway 1250/10%	17575IN0770181	$601.89	0.8092	1.0238	1.0000	1.0015	$102.92	$602.34	1.7079	$352.68
Anthem Gold Pathway 1250/10%	17575IN0770182	$601.89	0.8092	1.0515	1.0000	1.0015	$105.69	$618.63	1.7079	$362.21
Anthem Gold Pathway 1250/10%	17575IN0770183	$601.89	0.8092	0.9907	1.0000	1.0015	$99.60	$582.88	1.7079	$341.28
Anthem Gold Pathway 1250/10%	17575IN0770184	$601.89	0.8092	1.0609	1.0000	1.0015	$106.64	$624.15	1.7079	$365.45
Anthem Bronze Pathway POS 5000/40%	17575IN0780005	$601.89	0.5445	1.0648	1.0000	1.0015	$72.00	$421.49	1.7079	$246.79
Anthem Bronze Pathway POS 5000/40%	17575IN0780006	$601.89	0.5445	1.0816	1.0000	1.0015	$73.14	$428.17	1.7079	$250.70
Anthem Bronze Pathway POS 5000/40%	17575IN0780007	$601.89	0.5445	1.0865	1.0000	1.0015	$73.47	$430.09	1.7079	$251.82
Anthem Bronze Pathway POS 5000/40%	17575IN0780008	$601.89	0.5445	1.0874	1.0000	1.0015	$73.53	$430.46	1.7079	$252.04
Anthem Bronze Pathway POS 5000/40%	17575IN0780009	$601.89	0.5445	1.0632	1.0000	1.0015	$71.90	$420.88	1.7079	$246.43
Anthem Bronze Pathway POS 5000/40%	17575IN0780010	$601.89	0.5445	1.0676	1.0000	1.0015	$72.19	$422.61	1.7079	$247.44
Anthem Bronze Pathway POS 5000/40%	17575IN0780011	$601.89	0.5445	1.0640	1.0000	1.0015	$71.95	$421.17	1.7079	$246.60
Anthem Bronze Pathway POS 5000/40%	17575IN0780012	$601.89	0.5445	1.0640	1.0000	1.0015	$71.95	$421.20	1.7079	$246.62
Anthem Bronze Pathway POS 5000/40%	17575IN0780013	$601.89	0.5445	1.0641	1.0000	1.0015	$71.95	$421.21	1.7079	$246.62
Anthem Bronze Pathway POS 5000/40%	17575IN0780014	$601.89	0.5445	1.0617	1.0000	1.0015	$71.79	$420.27	1.7079	$246.07
Anthem Bronze Pathway POS 5000/40%	17575IN0780015	$601.89	0.5445	1.0614	1.0000	1.0015	$71.77	$420.15	1.7079	$246.00
Anthem Bronze Pathway POS 5000/40%	17575IN0780016	$601.89	0.5445	1.0557	1.0000	1.0015	$71.39	$417.93	1.7079	$244.70
Anthem Bronze Pathway POS 5000/40%	17575IN0780017	$601.89	0.5445	1.0480	1.0000	1.0015	$70.87	$414.87	1.7079	$242.91
Anthem Bronze Pathway POS 5000/40%	17575IN0780018	$601.89	0.5445	1.0238	1.0000	1.0015	$69.24	$405.28	1.7079	$237.30
Anthem Bronze Pathway POS 5000/40%	17575IN0780019	$601.89	0.5445	1.0515	1.0000	1.0015	$71.10	$416.24	1.7079	$243.71
Anthem Bronze Pathway POS 5000/40%	17575IN0780020	$601.89	0.5445	0.9907	1.0000	1.0015	$67.00	$392.19	1.7079	$229.63
Anthem Bronze Pathway POS 5000/40%	17575IN0780021	$601.89	0.5445	1.0609	1.0000	1.0015	$71.74	$419.95	1.7079	$245.89
Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan	17575IN0930005	$601.89	0.7038	0.9797	1.0000	1.0015	$85.67	$501.34	1.7079	$293.54
Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan	17575IN0930006	$601.89	0.8206	0.9797	1.0000	1.0015	$99.91	$584.56	1.7079	$342.27

Notes:

{1} This adjustment assumes a healthier than average population will select the catastrophic plan. The catastrophic adjustment factor is normalized to 1.0 across all plans for revenue neutrality across the entire block.

{2} The Plan Adjusted Index Rate is calculated by multiplying the Market Adjusted Index Rate by the AV and cost sharing, provider network, benefits in addition to the EHBs, and catastrophic plan adjustments and then adding the administrative costs. The Plan Adjusted Index Rate can also be described as a Plan Level Required Premium.

{3} See Exhibit H - Calibration.

{4} The Consumer Adjusted Premium Rate is calculated by dividing the Plan Adjusted Index Rate by the Calibration Factor. The Consumer Adjusted Premium Rate can also be described as a Plan Level Base Rate.

Exhibit P - Membership Projections for Cost-Sharing Reductions

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Silver Plan	Projected Membership by Subsidy Level:			
HIOS Standard Component Plan ID	100-150%	150%-200%	200%-250%	Standard
17575IN0700026	3,667	2,657	1,370	5,153
17575IN0700028	3,667	2,657	1,370	5,153
17575IN0700027	3,667	2,657	1,370	5,153
17575IN0770022	0	0	0	540
17575IN0770105	0	0	0	420
17575IN0770106	0	0	0	120
17575IN0770107	0	0	0	125
17575IN0770108	0	0	0	62
17575IN0770109	0	0	0	121
17575IN0770110	0	0	0	162
17575IN0770111	0	0	0	125
17575IN0770112	0	0	0	114
17575IN0770113	0	0	0	1,099
17575IN0770114	0	0	0	263
17575IN0770115	0	0	0	134
17575IN0770116	0	0	0	285
17575IN0770117	0	0	0	105
17575IN0770118	0	0	0	190
17575IN0770119	0	0	0	262
17575IN0770120	0	0	0	314
17575IN0770019	0	0	0	540
17575IN0770121	0	0	0	420
17575IN0770122	0	0	0	120
17575IN0770123	0	0	0	125
17575IN0770124	0	0	0	62
17575IN0770125	0	0	0	121
17575IN0770126	0	0	0	162
17575IN0770127	0	0	0	125
17575IN0770128	0	0	0	114
17575IN0770129	0	0	0	1,099
17575IN0770130	0	0	0	263
17575IN0770131	0	0	0	134
17575IN0770132	0	0	0	285
17575IN0770133	0	0	0	105
17575IN0770134	0	0	0	190
17575IN0770135	0	0	0	262
17575IN0770136	0	0	0	314
17575IN0770020	0	0	0	540
17575IN0770137	0	0	0	420
17575IN0770138	0	0	0	120
17575IN0770139	0	0	0	125
17575IN0770140	0	0	0	62
17575IN0770141	0	0	0	121
17575IN0770142	0	0	0	162
17575IN0770143	0	0	0	125
17575IN0770144	0	0	0	114
17575IN0770145	0	0	0	1,099
17575IN0770146	0	0	0	263
17575IN0770147	0	0	0	134
17575IN0770148	0	0	0	285
17575IN0770149	0	0	0	105
17575IN0770150	0	0	0	190
17575IN0770151	0	0	0	262
17575IN0770152	0	0	0	314
17575IN0770021	0	0	0	540
17575IN0770153	0	0	0	420
17575IN0770154	0	0	0	120
17575IN0770155	0	0	0	125
17575IN0770156	0	0	0	62
17575IN0770157	0	0	0	121
17575IN0770158	0	0	0	162
17575IN0770159	0	0	0	125
17575IN0770160	0	0	0	114
17575IN0770161	0	0	0	1,099
17575IN0770162	0	0	0	263
17575IN0770163	0	0	0	134
17575IN0770164	0	0	0	285
17575IN0770165	0	0	0	105
17575IN0770166	0	0	0	190
17575IN0770167	0	0	0	262
17575IN0770168	0	0	0	314
17575IN0930005	3,667	2,657	1,370	5,153

SERFF Tracking #:	*AWLP-129529773*	***State Tracking #:***	*IN_ONHIX_HMHS(1/15)*	***Company Tracking #:***	

State:	*Indiana*	***Filing Company:***	*Anthem Insurance Companies, Inc.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)*		
Product Name:	*IN 2015 - On- and Off-Exchange - IND*		
Project Name/Number:	*/*		

Supporting Document Schedules

Bypassed - Item:	10 Individual Checklist (Accident & Health)
Bypass Reason:	N/A - products offered are HMO/POS; used 12(A) checklist
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	10(A) Individual Checklist (Accident & Health)
Comments:	
Attachment(s):	12A_Individual_HMO_Checklist_On Hix.pdf 12A_Individual_HMO_Checklist_Off Hix.pdf
Item Status:	
Status Date:	

Bypassed - Item:	20(C) Out of State Association/Trust Products Checklist (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	4.1 Individual New Rate/Form Requirements (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0 Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	4.1(A) QHP Individual New Rate/Form Requirements (Accident & Health)
Comments:	See attachments below.
Attachment(s):	
Item Status:	

Status Date:	

Bypassed - Item:	7.0(A) QHP Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	4.1(B) EHB Individual New Rate/Form Requirements (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	7.0(B) EHB Individual Rate Adjustment Requirements (Accident & Health)
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	04 Major Medical Experience Workbook (Accident & Health)
Bypass Reason:	Not required for this year's ACA filing.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	09 SERFF Data Field Guide (Accident & Health)
Comments:	No attachment required.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	03 PPACA Uniform Compliance Summary
Bypass Reason:	N/A
Attachment(s):	
Item Status:	
Status Date:	

SERFF Tracking #:	*AWLP-129529773*	***State Tracking #:***	*IN_ONHIX_HMHS(1/15)*	***Company Tracking #:***	

State:	*Indiana*	***Filing Company:***	*Anthem Insurance Companies, Inc.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)*		
Product Name:	*IN 2015 - On- and Off-Exchange - IND*		
Project Name/Number:	*/*		

Satisfied - Item:	Readability Certification IN_ON and OFF HIX_1-15
Comments:	
Attachment(s):	Readability Cert_IN ON and OFF HIX_1-15.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Red-lined versions of IN POS On and Off Exchange contracts from 2014 to 2015
Comments:	
Attachment(s):	Red-lined version of IN POS_ON HIX contract from 2014 to 2015.pdf Red-lined version of IN POS_OFF HIX contract from 2014 to 2015.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Red-lined version of the IN HMO Off Exchange contract from 2014 to 2015
Comments:	
Attachment(s):	Red-lined version of IN HMO_OFF HIX contract from 2014 to 2015.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Red-lined version of the IN HMO On Exchange contract from 2014 to 2015
Comments:	Per your request, we have created a new red-line version of the HMO ON HIX. This version should be easier to read.
Attachment(s):	Red-line version of IN HMO ON HIX from 2014 to 2015.pdf
Item Status:	
Status Date:	

Satisfied - Item:	EHB Crosswalk Tools for each of the 4 contracts filed
Comments:	
Attachment(s):	Individual_HMO_OnHIX_EHB_Crosswalk.pdf Individual_HMO_OffHIX_EHB_Crosswalk.pdf Individual_POS_OnHIX_EHB_Crosswalk.pdf Individual_POS_OffHIX_EHB_Crosswalk.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Statement of Variability
Comments:	6/3/14 - Replaced SOV, per an error found by Product Management in one of the Plan names. I have corrected the one plan name and indicated the change in red text. TR
Attachment(s):	SOV_HMO and POS ON and OFF HIX_2015.pdf

SERFF Tracking #:	*AWLP-129529773*	***State Tracking #:***	*IN_ONHIX_HMHS(1/15)*	***Company Tracking #:***	

State:	*Indiana*	***Filing Company:***	*Anthem Insurance Companies, Inc.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)*		
Product Name:	*IN 2015 - On- and Off-Exchange - IND*		
Project Name/Number:	*/*		

Item Status:	
Status Date:	

Satisfied - Item:	Screenshots
Comments:	
Attachment(s):	Screenshots_17575IN070_17575IN076_17575IN093 - INDIV On-Exchange.pdf Screenshots_17575IN077_17575IN078 - INDIV Off-Exchange_Part1.pdf Screenshots_17575IN077_17575IN078 - INDIV Off-Exchange_Part2.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	IN IND Act_Memo_Output 5.9.14.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Red-line version comparing HMO ON HIX 2015 original contract to Final HMO ON HIX 2015 contract_7-29-14
Comments:	Per a phone conversation with Kim Isles of last week, I have made revisions to the Member Grievances section specifically re: the MSP products. Per her request, I have included this red-line of changes. The red-line version below should show only the last changes made to the Member Grievances section...the first set of optional language represents the NON-MSP products, and the second set of optional language (Expedited Review, External Grievances) represents the MSP products. Please let me know if you still have questions about these changes... Thanks, Traci
Attachment(s):	FINAL IN_HMO_ON HIX redline version_7-29-14.pdf
Item Status:	
Status Date:	

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name_____ **NAIC #** _____

Form number(s)_____ **Filing date**_____

Product Type: ☐ **Major Medical** ☐ **Pediatric Stand-Alone Dental**

Exchange Participation: ☐ **Off-Exchange** ☐ **On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.		
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm		
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.		
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.		
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*		
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.		
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**		
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**		
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**		
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**		
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**		
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**		
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**		
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**		
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**		
IC 27-13-36.2	**CLEAN CLAIMS**		
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**		
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**		
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**		
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**		
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**		
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**		
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**		
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**		
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**		
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**		
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**		
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.		
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**		
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))		
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.		
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.		
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance		
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits		
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)		
IC 27-8-5-21	**ADOPTED CHILDREN**		
IC 27-8-5.6-2(b)	**NEWBORNS**		
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**		
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**		
IC 27-8-24	**MINIMUM MATERNITY STAYS**		
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**		
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**		
IC 27-8-26	Individuals without regard to **GENETIC TESTING**		
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**		
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:-**Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727		
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136		
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug		
Bulletin 172	**CHEMOTHERAPY PARITY**		
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**		
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**		
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.		
IC 27-13-7-2	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.		
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.		
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.		
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.		
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.		
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.		
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.		
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.		
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)		
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)		
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**		
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**		
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302		
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302		
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302		
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302		
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302		
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760		
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)		
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126		
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715		
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)		
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)		
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)			
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)		
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)		
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)		
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)		
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)		
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)		
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)		
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330		
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.		

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature:_____

Printed Name:_____

Title: _____

Company: _____

Date: _____

Indiana Department of Insurance
Company Filing Checklist - Policy Review Standards

12(A) Non-Grandfathered
HMO Individual Major Medical & Dental

This checklist must be submitted with any form filings for HMO Individual Major Medical or HMO Individual Dental plans that are not Grandfathered. This checklist should also be used for HMO Individual Major Medical or Dental plans that are seeking certification as a Qualified Health Plan for Health Exchange participation.

Please attach this completed checklist as a PDF to your electronic filing.

Company Name_____ **NAIC #** _____

Form number(s)_____ **Filing date**_____

Product Type: ☐ **Major Medical** ☐ **Pediatric Stand-Alone Dental**

Exchange Participation: ☐ **Off-Exchange** ☐ **On-Exchange**

Adult Dental: Adult Dental (all dental plans other than Pediatric Stand-Alone Dental plans) should use the Grandfathered Company Filing Checklist (either non-HMO or HMO, as appropriate). It is assumed that Adult Dental plans will not apply for Exchange participation. Contact the Indiana Department of Insurance for further clarification, if needed.

Requirements in this checklist include:

Instructions:

This document is intended to provide a checklist for form filings of the applicable Accident and Health product. The checklist contains (1) specific requirements/provisions and (2) certifications that the Insurer has acknowledged and is in compliance with particular laws, regulations and bulletins. Additionally, this checklist is intended to provide supplementary information regarding certain laws, regulations and/or bulletins. When providing the completed checklist, the Insurer is expected to address **each** checklist line item in the column labeled "Response" as follows:

- Provide the specific location(s) in the documents provided which address the requirement; or
- Provide an affirmative statement or initial that the certification is being given; or
- Provide an explanation as to why the Insurer believes the item is not applicable for the product submitted for review.

All checklist line items require a response. Failure to provide a fully completed checklist may result in a delay of regulatory approval.

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
A. General Filing Requirements			
IC 27-1-3-15	**FILING FEES:** The fees are $35 per form plus $35 for rates or the retaliatory fees based on your state of domicile, whichever is greater. Filing fee compliance includes general compliance with SERFF user/filing fees as related to utilizing Electronic Funds Transfer (EFT) payment method.		
IC 27-1-26	**FLESCH READABILITY:** Complete a Flesch readability certification.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**TEMPLATE:** Complete the data templates via SERFF: For Form Filings Only • Plans and Benefits Template For Rates and Forms Filing • Administrative Data • Essential Community Providers • Plans and Benefit • Prescription Drug • Network • Service Area • Rates • Business Rules • Unified Rate Review Template Templates are available at http://www.serff.com/plan_management_data_templates_2015.htm		
Bulletin 125	**RATE FILING REQUIREMENTS:** 1. All new product filings must include rates 2. Any form filing that impacts rates must be accompanied by the related rate justification 3. If rates change for any reason, they must be submitted for review. See the IDOI website for filing instructions indicating which Rate Filing Requirements document is applicable to the product being filed.		
Bulletin 125	**FILING DESCRIPTION/COVER/LETTER/NAIC TRANSMITTAL:** Each filing must contain a complete description of the filing using one of the following methods: (1) In SERFF on the General Tab - Filing Description; (2) As a note referring to an NAIC Transmittal Document. If using a Cover Letter, please attach the document to the Supporting Documentation Tab within SERFF.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
Bulletin 125	**CONSULTING AUTHORIZATION:** If the filing is submitted by an outside consulting firm, a letter giving authorization to file on behalf of the company. If you are filing for multiple companies, you must submit an authorization from each Company, list each company separately on the cover letter by NAIC #, Company Name and form #. Separate filing/retaliatory fees for each company will be applicable.		
Bulletin 125	**ACKNOWLEDGEMENT:** All IDOI instructions, checklists and requirements for accident and health rate and/or form filings have been satisfied and are in compliance with PPACA and state requirements. *Please acknowledge.*		
Bulletin 125	**ESSENTIAL HEALTH BENEFITS CROSSWALK TOOL:** Must be completed and include it in your SERFF filing under supporting documents tab for both QHP and Non-QHP filings.		
B. Required Provisions	**Policies MUST contain the following provisions, AS STATED, with the captions, or alternative appropriate captions. IF the provision does not apply, the Insurer may omit or amend WITH THE APPROVAL OF THE DEPARTMENT**		
IC 27-13-7-3(a)(1)	**THE NAME AND ADDRESS OF THE HEALTH MAINTENANCE ORGANIZATION**		
IC 27-13-7-3(a)(2)	**ELIGIBILITY REQUIREMENTS**		
IC 27-13-7-3(a)(3)	**BENEFITS AND SERVICES WITHIN THE SERVICE AREA**		
IC 27-13-7-3(a)(4) IC 27-13-36-9	**EMERGENCY CARE BENEFITS AND SERVICES**		
IC 27-13-7-3(a)(5)	**ANY OUT-OF-AREA BENEFITS AND SERVICES**		
IC 27-13-7-3(a)(6)	**COPAYMENTS, DEDUCTIBLES, AND OTHER OUT-OF-POCKET COSTS**		
IC 27-13-7-3(a)(7)	**LIMITATIONS AND EXCLUSIONS**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(8)	**ENROLLEE TERMINATION PROVISIONS**		
IC 27-13-7-3(a)(9)	**ANY ENROLLEE REINSTATEMENT PROVISIONS**		
IC 27-13-7-3(a)(10)	**CLAIMS PROCEDURES**		
IC 27-13-36.2	**CLEAN CLAIMS**		
IC 27-13-7-3(a)(11)	**ENROLLEE GRIEVANCE PROCEDURES**		
IC 27-13-7-3(a)(12)	**CONTINUATION OF COVERAGE PROVISIONS**		
IC 27-13-7-3(a)(13)	**CONVERSION PROVISIONS**		
IC 27-13-7-3(a)(14)	**EXTENSION OF BENEFIT PROVISIONS**		
IC 27-13-7-3(a)(15) 760 IAC 1-38.1	**COORDINATION OF BENEFIT PROVISIONS. NOT APPLICABLE FOR LIMITED SERVICE HEALTH MAINTENANCE ORGANIZATIONS**		
IC 27-13-7-3(a)(16)	**ANY SUBROGATION PROVISIONS**		
IC 27-13-7-3(a)(17)	**A DESCRIPTION OF THE SERVICE AREA**		
IC 27-13-7-3(a)(18)	**THE ENTIRE CONTRACT PROVISIONS**		
IC 27-13-7-3(a)(19)	**THE TERM OF THE COVERAGE PROVIDED BY THE CONTRACT**		
IC 27-13-7-3(a)(20)	**ANY RIGHT OF CANCELLATION OF THE GROUP OR INDIVIDUAL CONTRACT HOLDER**		
IC 27-13-7-3(a)(21)	**RIGHT OF RENEWAL PROVISIONS**		
IC 27-13-7-3(a)(22)	**PROVISIONS REGARDING REINSTATEMENT OF A GROUP OR AN INDIVIDUAL CONTRACT HOLDER**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-3(a)(23)	**GRACE PERIOD PROVISIONS** For On-Exchange products see the section of this checklist titled "Specific Requirements for Qualified Health Plans" for grace Period requirements.		
IC 27-13-7-3(a)(24)	**A PROVISION ON CONFORMITY WITH STATE LAW**		
IC 27-13-7-3(a)(25)	**GUARANTEED RENEWABILITY:** A provision or provisions that comply with the: (A) guaranteed renewability; and (B) group portability; requirements of the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1))		
IC 27-13-7-3(a)(26) IC 27-8-5-28 Bulletin 189	**DEPENDENT AGE 26** A policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child of the policyholder or certificate holder, upon request of the policyholder or certificate holder, until the date that the child becomes twenty-six (26) years of age. Indiana Public Law 160-2011 requires Insurers and HMOs that offer dependent coverage to make the coverage available until a child reaches the age of 26. Consistent with the federal law, coverage cannot be restricted regardless of financial dependency, residency, marital status, student status, employment, eligibility for other coverage, or IRS qualification. This requirement applies to natural and adopted children, stepchildren, and children subject to legal guardianship.		
IC 27-13-7-4	**FREE LOOK:** 10 day "free look" provision		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-10 IC 27-13-10.1 760 IAC 1-59	**GRIEVANCE AND APPEALS PROCEDURES:** Provisions should be provided which describe a three tier process for handling (1) internal grievances, (2) internal appeals and (3) external appeals and the related time frames for each tier.		
Bulletin 128	**NOTICE:** Notice to policyholders regarding filing complaints with the Department of Insurance		
C.HMO Individual A&H Policies *must provide*			
IC 27-8-5-15.6(e)	**SUBSTANCE ABUSE PARITY**—when abuse treatment provided in conjunction with health treatment it must provide coverage in parity with other medical benefits		
IC 27-8-5-19(c)(17)	**HANDICAPPED CHILDREN** beyond the age of maturity. (with 120 days notice to the company)		
IC 27-8-5-21	**ADOPTED CHILDREN**		
IC 27-8-5.6-2(b)	**NEWBORNS**		
IC 27-8-14.5	**DIABETES TREATMENT, SUPPLIES, EQUIPMENT & EDUCATION**		
IC 27-8-20	**OFF-LABEL USE OF CERTAIN DRUGS**		
IC 27-8-24	**MINIMUM MATERNITY STAYS**		
IC 27-8-24.3	**VICTIMS OF ABUSE WITHOUT REGARD TO THE ABUSE**		
IC 27-8-24-4	**INFANT SCREENING TESTS REQUIRED BY IC 16-41-17-2**		
IC 27-8-26	Individuals without regard to **GENETIC TESTING**		
IC 27-13-7-13	**CONTINUATION OF COVERAGE STATEMENT**		
IC 27-13-7-15	**DENTAL ANESTHESIA/HOSPITALIZATION**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-14	**BREAST RECONSTRUCTION AND PROSTHESIS FOLLOWING MASTECTOMY:-**Regardless of coverage at time of mastectomy Coverage must include: 1. Reconstruction of the breast on which the mastectomy was performed (all stages); 2. Surgery and reconstruction of the other breast to produce symmetrical appearance; 3. Prostheses; and 4. Treatment of physical complications at all stages of mastectomy PHSA §2727		
IC 27-13-7-14.8	**MENTAL HEALTH PARITY**; Substance abuse parity with mental health parity offered Effective January 1, 2014, plans covering mental health and substance abuse treatment services in addition to medical or surgical services may not impose financial requirements and treatment limitations that are more restrictive than the predominate requirements and limitations that apply to substantially all medical and surgical services. Annual and lifetime dollar limits only apply if mental health and substance abuse disorders are part of the Essential Health Benefits. Financial requirements and quantitative and non-quantitative limitation requirements for mental health and substance use disorder Availability of medical necessity criteria for mental health determinations 45 CFR §146.136		
IC 27-13-37.5-2	**PRESCRIPTION DRUG:** Can't require use of specific mail order pharmacy for coverage		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-38-1	**PRESCRIPTION DRUG:** Allows formularies but requires process for obtaining non-formulary drug		
Bulletin 172	**CHEMOTHERAPY PARITY**		
760 IAC 1-39-7	**AIDS, HIV AND RELATED CONDITIONS**		
COBRA/ERISA	**OPPORTUNITY FOR COBRA COVERAGE IF EMPLOYER HAS 20 OR MORE EMPLOYEES**		
D. General Regulatory Issues	**Under the authority provided by IC 27-4-1-4, 27-8-5-1.5 and 27-13-7-2, the Department monitors various issues that have been determined to be unjust, unfair, inequitable, misleading, deceptive, or encourage the misrepresentation of the policy or potentially constitute unfair trade practices. The following issues will be reviewed.**		
IC 27-13-7-2	**APPLICATION QUESTIONS:** 1. Questions regarding an applicant's health cannot inquire about non-specific conditions prior to the most recent five years. 2. Questions inquiring if an applicant has had signs or symptoms of a condition are not permitted.		
IC 27-13-7-2	**ARBITRATION**: Mandatory and/or binding arbitration provisions are prohibited.		
IC 27-13-7-2	**LARGE ENDORSEMENTS:** The Department does not allow use of large or confusing endorsements to bring contracts into compliance. In such cases the entire contract should be refiled to incorporate the multiple changes. On a similar note, Indiana specific certificates should be filed rather than file an endorsement to revise another state's certificate.		
IC 27-13-7-2	**OPEN ENDORSEMENTS:** Highly flexible or "blank check" type endorsement forms that provide unlimited ability to revise forms without regulatory review are not allowed.		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-7-2	**PROHIBITED PROVISIONS:** The policy form cannot contain provisions that are unjust, unfair, inequitable, misleading, or deceptive, or that encourage misrepresentation of the policy.		
IC 27-13-7-2	**VARIOUS FEES:** Fees charged to accept or process an application are not allowed. One-time fees such as may be charged to issue a policy are acceptable providing they are clearly labeled and accompanied by a disclosure that the fee is fully refundable if the policy is not issued, not taken or returned during the "free look" period.		
IC 27-8-5-19(c)(6) IC 27-8-5-2.5	**FIRST MANIFEST LANGUAGE:** Typically first manifest type language creates a permanent exclusion of coverage related to a condition present any time prior to the effective date of coverage contrary to any pre-existing condition provisions included in the form. Such inconsistencies are not permitted.		
Bulletin 103	**FULL AND FINAL DISCRETION**: No full and final discretion clauses except where policy is governed by ERISA.		
Bulletin 106	**FOREIGN LANGUAGE FORMS**: Foreign language forms must comply with Bulletin 106.		
E. HMO Individual A&H must cover	Due to the EHB benchmark requirements, the following must be covered.		
IC 27-13-7-14.7 Bulletin 136 Bulletin 179	**AUTISM SPECTRUM DISORDERS (PREVIOUSLY PDD):** As per Bulletins 136 and 179, "Coverage for services provided as prescribed by the insured's treating physician in accordance with treatment plan." Autism Spectrum Disorders includes Asperger's Syndrome and Autism.		
IC 27-13-7-15.3	**MAMMOGRAPHY** (Baseline, then 1 per year after 40 unless high risk)		
IC 27-13-7-16	**PROSTATE CANCER SCREENING** (1 per year after 50 unless high risk)		
IC 27-13-7-17 IC 27-8-14.8	**COLORECTAL CANCER SCREENING**		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-13-37-4	**POINT-OF SERVICE PRODUCT**		
IC 27-13-7-18	**INHERITED METABOLIC DISEASE**		
F. ACA Must Provide	**All Essential Health Benefits and related Essential Health Benefit requirements are applicable for plans with effective dates on or after January 1, 2014. All other requirements are effective currently unless otherwise noted.**		
IC 27-8-5-1(c)	Category 1 Essential Health Benefit – **AMBULATORY PATIENT SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 2 Essential Health Benefit – **EMERGENCY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 3 Essential Health Benefit – **HOSPITALIZATION** ACA §1302		
IC 27-8-5-1(c)	Category 4 Essential Health Benefit – **MATERNITY AND NEWBORN CARE** Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. ACA §1302		
IC 27-8-5-1(c)	Category 5 Essential Health Benefit – **MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT** ACA §1302		
IC 27-8-5-1(c)	Category 6 Essential Health Benefit – **PRESCRIPTION DRUGS** ACA §1302		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 7 Essential Health Benefit – **REHABILITATIVE AND HABILITATIVE SERVICES AND DEVICES** Insurer must provide sufficient documentation regarding habilitative services and devices benefits and definitions. ACA §1302		
IC 27-8-5-1(c)	Category 8 Essential Health Benefit – **LABORATORY SERVICES** ACA §1302		
IC 27-8-5-1(c)	Category 9 Essential Health Benefit – **PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT** Coverage of preventive services without cost-sharing requirements including deductibles, co-payments, and co-insurance. Covered preventive services include the current recommendations of the USPSTF http://www.uspreventiveservicestaskforce.org/recommendations.htm ACA §1302 PHSA §2713 75 Fed Reg 41726 45 CFR §147.130		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	Category 10 Essential Health Benefit – **PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE** Insurer must indicate if Pediatric dental services are being included or excluded from essential health benefits in lieu of an Exchange-certified stand-alone dental plan. This applies to plans both on and off the Exchange. Pediatric vision care must be included in the essential health benefits for plans both on and off the Exchange. ACA §1302		
IC 27-8-5-1(c)	**MATERIAL MODIFICATIONS** Provide 60 days advance notice to enrollees before the effective date of any material modifications including changes in preventive benefits *Please Acknowledge* PHSA §2715 75 Fed Reg 41760		
IC 27-8-5-1(c)	**COVERAGE FOR DEPENDENT STUDENT ON MEDICALLY NECESSARY LEAVE OF ABSENCE ("MICHELLE'S LAW")** Issuer cannot terminate coverage due to a medically necessary leave of absence Change in benefits prohibited Eligibility for protections *Please Acknowledge* PHSA §2728 45 CFR §147.145		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITATIONS ON ESSENTIAL HEALTH BENEFITS:** The plan does not include routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/custodial nursing home care benefits, or non-medically necessary orthodontia as Essential Health Benefits. 45 CFR §156.115(d)		
IC 27-8-5-1(c)	**NO LIFETIME LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** **NO ANNUAL LIMITS ON THE DOLLAR VALUE OF ESSENTIAL HEALTH BENEFITS** *Please Acknowledge* PHSA §2711 75 Fed Reg 37188 45 CFR §147.126		
IC 27-8-5-1(c)	**ESSENTIAL HEALTH BENEFIT FORMULARY REVIEW**: The plan (1) Covers at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the Essential Health Benefit-benchmark plan; and (2) Submits its drug list to the Exchange, the State, or Office of Personnel Management (OPM). *Please Acknowledge* 45 CFR §156.122(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SUMMARY OF BENEFITS COVERAGE:** The Summary of Benefits Coverage must reflect the covered Essential Health Benefits, cost-sharing and Actuarial Value (metal level) that the final approved rates and forms permit. Submission of the Summary is not required as a part of this filing; however, filer must certify to the completion and conformity with regulatory requirements of the Summary. *Please Acknowledge* PHSA §2715		
IC 27-8-5-1(c)	**NO PRE-EXISTING CONDITION EXCLUSIONS:** A pre-existing exclusion includes any limitation or exclusion of benefits (including denial of coverage) applicable to an individual as a result of information relating to an individual's health status before the individuals effective date of coverage. *Please Acknowledge* PHSA §§2704; 1255 75 Fed Reg 37188 45 CFR §147.108		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**MARKETING:** Insurer and its officials, employees, agents and representatives comply with any applicable state laws and regulations regarding marketing by health insurance Insurers and do not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(e)		
IC 27-8-5-1(c)	**PROHIBITION ON DISCRIMINATION:** The plan's benefit design, or the implementation of its benefit design, does not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.125		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED AVAILABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must offer to any individual in Indiana all products that are approved for sale in the individual market, and must accept any individual that applies for any of those products, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(a)		
IC 27-8-5-1(c)	**OPEN ENROLLMENT**: Insurer must allow an individual to purchase health insurance coverage during the initial and annual open enrollment periods and coverage effective dates consistent with the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL ENROLLMENT:** Insurer has special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. These special enrollment periods are in addition to any other special enrollment periods that are required under federal and state law. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b) 45 CFR §155.410		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**LIMITED OPEN ENROLLMENT:** Insurer must provide a limited open enrollment period for the events described in Section 155.420(d) of the Affordable Care Act (excluding subsections (d)(3) concerning citizenship status, (d)(8) concerning Indians and (d)(9) concerning exceptional circumstances). Additionally, the Insurer must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014. Enrollees must be provided 60 calendar days after the date of an event, described in this section, to elect coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(b)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**SPECIAL RULES FOR NETWORK PLANS:** (1) If Insurer offers health insurance coverage through a network plan, the Insurer may: (i) Limit the individuals who may apply for the coverage to those who live or reside in the service area for the network plan. (ii) Within the service area of the plan, deny coverage to individuals if the Insurer has demonstrated to the IDOI the following: (A) It will not have the capacity to deliver services adequately to enrollees of any additional individuals because of its obligations to enrollees. (B) It is applying this section uniformly to all individuals without regard to the claims experience of those individuals, or any health status-related factor relating to such individuals. (2) An Insurer that denies health insurance coverage to an individual in any service area may not offer coverage in the individual market within the service area to any individual for a period of 180 calendar days after the date the coverage is denied. This does not limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. (3) Coverage offered within a service area after the 180-day period is subject to the same requirements. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**APPLICATION OF FINANCIAL CAPACITY LIMITS:** Insurer is aware that it may deny health insurance coverage in the individual market if it has demonstrated to IDOI limitations provided in the Affordable Care Act. An Insurer is also aware that if it denies health insurance coverage to any individual in Indiana under the financial capacity limitations, it may not offer coverage in the individual market in Indiana for at least 180 days. This limitation does not however limit the Insurer's ability to renew coverage already in force or relieve the Insurer of the responsibility to renew that coverage. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.104(d)			
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE:** Insurer is aware that if it offers health insurance coverage in the individual market in Indiana it must renew or continue in force the coverage at the option of the individual, subject to exclusions allowed by the Affordable Care Act. Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(a)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**GUARANTEED RENEWABILITY OF COVERAGE EXCEPTIONS:** Insurer may non-renew or discontinue health insurance coverage offered in the individual market based only on one or more of the following: (1) Nonpayment of premiums (2) Fraud (3) Violation of participation or contribution rules (4) Termination of plan (5) Enrollees' movement outside service area (6) Association membership ceases Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §147.106(b)		
IC 27-8-5-1(c)	**DISCONTINUING PRODUCTS:** Insurer is aware of the requirements to discontinue a particular health insurance plan in Indiana including: (1) Notice provision (2) Requirement to offer other health insurance coverage currently offered (3) Acting without regard to claims experience or health status-related factor Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**DISCONTINUING ALL COVERAGE:** Insurer is aware of the requirements to discontinue all individual, group or all markets of health insurance coverage in Indiana including: (1) Notice provision (2) 5-year discontinuation period Applicable for plans with effective dates on or after January 1, 2014. *Please Acknowledge* 45 CFR §147.106(d)		
IC 27-8-5-1(c)	**COVERAGE THROUGH ASSOCIATIONS**: Any reference to "plan sponsor" is deemed, with respect to coverage provided to an employer member of the association, to include a reference to the employer. Applicable for major medical plans with effective dates on or after January 1, 2014. 45 CFR §147.106(f)		
IC 27-8-5-1(c)	**CLINICALLY APPROPRIATE DRUGS**: Insurer has procedures in place that allows an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.122(c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**EMERGENCY DEPARTMENT SERVICES**: Cannot require prior authorization; Cannot be limited to only services and care for participating providers Must be covered at in-network cost-sharing level PHSA §2719A 75 Fed Reg 37188 45 CFR §147.138		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
IC 27-8-5-1(c)	**CATASTROPHIC PLANS:** If plan is a catastrophic plan, it meets the following conditions: (1) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market. (2) Does not provide a bronze, silver, gold, or platinum level of coverage. (3) Provides coverage of the Essential Health Benefits once the annual limitation on cost sharing is reached as defined in the Affordable Care Act (4) Provides coverage for at least three primary care visits per year before reaching the deductible. (5) Covers only individuals who meet either of the following conditions: (i) Have not attained the age of 30 prior to the first day of the plan year. (ii) Have received a certificate of exemption in accordance with the Affordable Care Act. A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services. For other than self-only coverage, each individual enrolled must meet the age or certificate of exemption requirements above. Applicable for plans with effective dates on or after January 1, 2014. 45 CFR §156.155		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
G. Specific Requirements for Qualified Health Plans	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the health plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Qualified Health Plan requirements are applicable for plans on the Exchange with effective dates on or after January 1, 2014.**		
	NETWORK ADEQUACY: Insurer's provider network meets the following standards: (1) Includes essential community providers in accordance with the Affordable Care Act; (2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and, (3) Is consistent with the network adequacy provisions of the Affordable Care Act. 45 CFR §§156.230 (a) & (b)		
	TERMINATION OF COVERAGE DUE TO NON-PAYMENT OF PREMIUM: Insurer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium. This policy for the termination of coverage: (1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and (2) Must be applied uniformly to enrollees in similar circumstances. 45 CFR §156.270 (c)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	GRACE PERIOD FOR RECIPIENTS OF ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT: Insurer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP Insurer must: (1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period; (2) Notify HHS of such non-payment; and, (3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. 45 CFR §156.270 (d)		
	SEGREGATION OF FUNDS FOR ABORTION SERVICES: Insurer must provide to the State Insurance Commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations. 45 CFR §156.280 (e)(5)		
	NOTICE FOR ABORTION SERVICES: Insurer that provides for coverage for abortion services must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage. 45 CFR §156.280 (f)		

Statute/Regulation	Requirement	Response	FOR IDOI USE ONLY Yes/No/Comments
	ENTIRE YEAR: Insurer must set rates for an entire benefit year. 45 CFR §156.255 (b)		
	NOTIFICATION TO THE FFM FOR CHANGES IN ELIGIBILITY REDETERMINATIONS: QHP issuer to notify the policy holder to contact the FFM for any changes to their eligibility determination. *Please acknowledge* 45 CFR §155.330		
H. Specific Requirements for Exchange Certified Stand-Alone Dental Plan	**Under the authority provided by IC 27-8-5-1 the Department is responsible for determining whether the plan submitted has met certain form requirements. Accordingly, the following items will be reviewed. All regulation references listed in this section are that of the final law or regulations of the Patient's Protection and Affordable Care Act unless otherwise indicated.** **All Exchange-Certified Stand-Alone Dental Plan requirements are applicable for plans intending to satisfy the Pediatric Dental Essential Health benefit, at a minimum, either on or off the Exchange. This type of plan has an effective date on or after January 1, 2014.**		
	EXCHANGE CERTIFIED STAND ALONE DENTAL: Insurer meets all requirements applicable to be considered Exchange-Certified. Insurer should provide the IDOI with requirements, if any, which are pending certification by the Exchange.		

By signing below, I am certifying on behalf of my company pursuant to Ind. Code 27-8-5-1.5(i)(1)(C) that our policy form(s) submitted with this checklist meets all of the applicable requirements of Indiana law and meets all the applicable requirements of federal law contained in the Patient Protection and Affordable Care Act. I understand and acknowledge, on behalf of my company, that the Indiana Department of Insurance is

relying on this certification in making its determination whether to approve or disapprove this policy filing. If any policy provision is not in compliance with Indiana law or the Patient Protection and Affordable Care Act, the Indiana Department of Insurance may take regulatory action against my company.

Signature:_____

Printed Name:_____

Title: _____

Company: _____

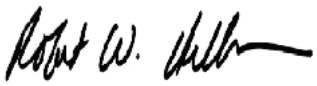
Date: _____

ANTHEM INSURANCE COMPANIES, INC.
Dba Anthem Blue Cross and Blue Shield

Readability Certification
For:
IN_ONHIX_HMHS(1/15)
IN_OFFHIX_HMHS(1/15)
IN_ONHIX_PS(1/15)
IN_OFFHIX_PS(1/15)

I, Robert W. Hillman, an officer of Anthem Insurance Companies, Inc., hereby certify that the above forms meet the minimum reading ease score calculated by the Flesch Reading Ease test as required by IC 27-1-26. The Flesch Reading Ease scores for the above form(s) are: 40.5; 40.7; 40.5; and 40.7

Anthem Blue Cross and Blue Shield



President

Summary
5/8/2014 4:16:33 PM

Differences exist between documents.

New Document:	**Old Document:**
IN_ONHIX_PS(1-15)	FINAL APPROVED IN_ONHIX_PS(1-14)_rev 7-3-13
109 pages (1.02 MB)	111 pages (989 KB)
5/8/2014 4:15:44 PM	5/8/2014 4:15:21 PM
Used to display results.	

Get started: first change is on page 1.

No pages were deleted

How to read this report

Highlight indicates a change.
~~**Deleted**~~ indicates deleted content.
indicates pages were changed.
indicates pages were moved.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  - Our company and services.
  - Our network of doctors and other health care providers.
  - your rights and responsibilities.
  - the rules of your health care plan.
  - the way your health plan works.
- Make a complaint or file an appeal about:
  - your health care plan.
  - any care you get.
  - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Network Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

	Network		**Non-Network**	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Calendar year deductible	$[0 - 5,000]	$[0 - 10,000]	$[0 - 15,000]	$[0 - 30,000]
The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]	$[0 - 30,000]	$[0 - 60,000]

	Network		**Non-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services	$[0]	[0 - 40]%	$[0]	[0 - 40]%
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.			
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.			
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0-3] visits; care is then subject to Deductible and Coinsurance for subsequent	$[0 - 50]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
visits.				
Specialty Care Provider (SCP)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Other Office Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Emergency room visits (Copayment waived if admitted)	$[0 - 200]	[0 - 40]%	$[0 - 200]	[0 - 40]%
Urgent Care Center	$[0 - 50]	[0 - 40]%	$[0 - 50]	[0 - 40]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year, Network and Non-Network combined, and a maximum of [164] visits per Member, per lifetime Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospice Care	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospital Services				
Inpatient	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Maximum limit of [60] days per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Mental Health & Substance Abuse				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Outpatient facility	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient office visit	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Diagnostic tests				
Laboratory	$[0]	[0 - 40]%	$[0]	[0 - 60]%
MRI, CT, & PET scan	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Radiology	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Speech, Occupational, and Manipulation Therapy** Limited to a maximum of [20] visits per Member, per Calendar Year for physical therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for occupational therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for speech therapy, Network and Non-Network combined. Limited to a maximum of [12] visits per Member, per Calendar Year for manipulation therapy, Network and Non-Network combined. **Cardiac Rehabilitation** Limited to a maximum of [36] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home	$[0]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.				
Preventive Care Services Network Care not subject to Deductible	$0	0%	$[0]	[0 - 60]%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Surgery				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient treatment	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Ambulatory Surgical Center	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.		Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]% Covered transplant procedure charges at a Non-Network Transplant Provider Facility will NOT apply to

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
				your Out-of-Pocket Maximum.
Prescription Drugs	**Participating Pharmacy**		**Non-Participating Pharmacy**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Retail (30-day supply)				
Tier 1	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 2	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Tier 4	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).				
Mail Order				
Tier 1 (90-day supply)	$[0]	[0 - 40]% [after Calendar Year Deductible]	Not Covered	
Tier 2 (90-day supply)	$[0]	[0 - 40] % [after Calendar Year Deductible]	Not Covered	
Tier 3	$[0]	[0 - 40]% after Calendar Year	Not Covered	

Prescription Drugs	Participating Pharmacy		Non-Participating Pharmacy	
	Copayment	Coinsurance	Copayment	Coinsurance
(90-day supply) Tier 4 (30-day supply)	$[0]	Deductible [0 - 40]% after Calendar Year Deductible	Not Covered	
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, Participating Specialty Pharmacy, or Non-Participating Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.			

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance	Pediatric Non-Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%	[0 - 10]%
Basic Restorative Services	[0 - 40]%	[0 - 40]%
Oral Surgery Services	[0 - 50]%	[0 - 50]%
Endodontic Services	[0 - 50]%	[0 - 50]%
Periodontal Services	[0 - 50]%	[0 - 50]%
Major Restorative Services	[0 - 50]%	[0 - 50]%
Prosthodontic Services	[0 - 50]%	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period.	[0 - 50]%	[0 - 50]%

Pediatric Vision Services The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.		
	Network Copayment	**Non-Network Payment Allowance**
Routine Eye Exam	$[0]	$[30]
[One per Calendar Year]		
Standard Plastic Lenses*		
[One per Calendar Year]		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]
Progressive	$[0]	$[40]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.		
Frames* (formulary) This Plan offers a selection of covered frames.	$[0]	$[45]
[One per Calendar Year]		
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	$[Covered in Full]	$[210]
[One per Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the Plan will pay for the services.

****

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no

Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Contract. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum

Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).

- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the "Member Grievances" section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Where You Can Obtain Prescription Drugs" section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for services rendered by Providers located outside the state of Indiana unless the services are for Emergency care, urgent care and ambulance services; or the services are approved in advance by Anthem.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related

means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the “Covered Services” section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage’s benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
- Gastric electrical stimulation.
- Hypnotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:

- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution
- Be capable of indicating intent
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution
- Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
- Not be emancipated
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract.

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers located in the state of Indiana; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits**.

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has

agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include but are not limited to:

- amounts over the Maximum Allowed Amount;
- amounts over any Contract maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Network Out-of-Pocket Limit is satisfied, no additional Network Coinsurance will be required for the remainder of the calendar year.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Coinsurance will be required for the remainder of the calendar year, except for out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Participating or Non-Participating Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or Cost-Share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances, you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating Cost-Share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize you to go to an available Non-Participating Provider for that Covered Service and We agree that the network Cost-Share will apply.

Your Plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost-Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, you may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Contract. You must exhaust the Plan's appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Anthem covers only limited healthcare services received outside of Our Service Area. For example, Emergency or Urgent Care obtained out of Our Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment or Coinsurance stated in this Contract.

Whenever you obtain covered services or supplies outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for Emergency or Urgent Care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Our Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, we may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting care in the right setting” paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by a Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center – a** Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner – A** duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife – When** services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant –** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Summary
5/8/2014 4:25:06 PM

Differences exist between documents.

New Document:	**Old Document:**
IN_OFFHIX_PS(1-15)	FINAL APPROVED IN_OFFHIX_PS(1-14)_rev 6-19-13
107 pages (1.00 MB)	108 pages (396 KB)
5/8/2014 4:24:18 PM	5/8/2014 4:23:56 PM
Used to display results.	

Get started: first change is on page 1.

No pages were deleted

How to read this report

Highlight indicates a change.
~~**Deleted**~~ indicates deleted content.
indicates pages were changed.
indicates pages were moved.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  - Our company and services.
  - Our network of doctors and other health care providers.
  - your rights and responsibilities.
  - the rules of your health care plan.
  - the way your health plan works.
- Make a complaint or file an appeal about:
  - your health care plan.
  - any care you get.
  - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Network Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

	Network		Non-Network	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Calendar year deductible	$[0 - 5,000]	$[0 - 10,000]	$[0 - 15,000]	$[0 - 30,000]
The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]	$[0 - 30,000]	$[0 - 60,000]

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services	$[0]	[0 - 40]%	$[0]	[0 - 40]%
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.			
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.			
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0-3] visits; care is then subject to Deductible and Coinsurance for subsequent	$[0 - 50]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
visits.				
Specialty Care Provider (SCP)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Other Office Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Emergency room visits (Copayment waived if admitted)	$[0 - 200]	[0 - 40]%	$[0 - 200]	[0 - 40]%
Urgent Care Center	$[0 - 50]	[0 - 40]%	$[0 - 50]	[0 - 40]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year, Network and Non-Network combined, and a maximum of [164] visits per Member, per lifetime Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospice Care	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospital Services				
Inpatient	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Maximum limit of [60] days per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Mental Health & Substance Abuse				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Outpatient facility	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient office visit	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Diagnostic tests				
Laboratory	$[0]	[0 - 40]%	$[0]	[0 - 60]%
MRI, CT, & PET scan	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Radiology	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Speech, Occupational, and Manipulation Therapy** Limited to a maximum of [20] visits per Member, per Calendar Year for physical therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for occupational therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for speech therapy, Network and Non-Network combined. Limited to a maximum of [12] visits per Member, per Calendar Year for manipulation therapy, Network and Non-Network combined. **Cardiac Rehabilitation** Limited to a maximum of [36] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home	$[0]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.				
Preventive Care Services Network Care not subject to Deductible	$0	0%	$[0]	[0 - 60]%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Surgery				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient treatment	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Ambulatory Surgical Center	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.		Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]% Covered transplant procedure charges at a Non-Network Transplant Provider Facility will NOT apply to

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
				your Out-of-Pocket Maximum.
Prescription Drugs	**Participating Pharmacy**		**Non-Participating Pharmacy**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Retail (30-day supply)				
Tier 1	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 2	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Tier 4	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).				
Mail Order				
Tier 1 (90-day supply)	$[0]	[0 - 40]% [after Calendar Year Deductible]	Not Covered	
Tier 2 (90-day supply)	$[0]	[0 - 40] % [after Calendar Year Deductible]	Not Covered	
Tier 3	$[0]	[0 - 40]% after Calendar Year	Not Covered	

Prescription Drugs	Participating Pharmacy		Non-Participating Pharmacy	
	Copayment	Coinsurance	Copayment	Coinsurance
(90-day supply) Tier 4 (30-day supply)	$[0]	Deductible [0 - 40]% after Calendar Year Deductible	Not Covered	
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, Participating Specialty Pharmacy, or Non-Participating Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.			

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance	Pediatric Non-Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%	[0 - 10]%
Basic Restorative Services	[0 - 40]%	[0 - 40]%
Oral Surgery Services	[0 - 50]%	[0 - 50]%
Endodontic Services	[0 - 50]%	[0 - 50]%
Periodontal Services	[0 - 50]%	[0 - 50]%
Major Restorative Services	[0 - 50]%	[0 - 50]%
Prosthodontic Services	[0 - 50]%	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period.	[0 - 50]%	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

	Network Copayment	Non-Network Payment Allowance
Routine Eye Exam	$[0]	$[30]
[One per Calendar Year]		
Standard Plastic Lenses*		
[One per Calendar Year]		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]
Progressive	$[0]	$[40]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.		
Frames* (formulary) This Plan offers a selection of covered frames.	$[0]	$[45]
[One per Calendar Year]		
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	$[Covered in Full]	$[210]
[One per Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the Plan will pay for the services.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Contract. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

  - Observation and assessment by a psychiatrist weekly or more often,
  - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum

Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).

- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the "Member Grievances" section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Where You Can Obtain Prescription Drugs" section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Helpful tip: Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Helpful tip: See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for services rendered by Providers located outside the state of Indiana unless the services are for Emergency care, urgent care and ambulance services; or the services are approved in advance by Anthem.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related

means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
- Custodial Care, convalescent care or rest cures.
- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
- Gastric electrical stimulation.
- Hypnotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:

- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond the Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications or other forms or statements the Plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

This section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract.

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers located in the state of Indiana; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits**.

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has

agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include but are not limited to:

- amounts over the Maximum Allowed Amount;
- amounts over any Contract maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Network Out-of-Pocket Limit is satisfied, no additional Network Coinsurance will be required for the remainder of the calendar year.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Coinsurance will be required for the remainder of the calendar year, except for out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Participating or Non-Participating Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or Cost-Share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances, you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating Cost-Share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize you to go to an available Non-Participating Provider for that Covered Service and We agree that the network Cost-Share will apply.

Your Plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost-Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, you may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Contract. You must exhaust the Plan's appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Anthem covers only limited healthcare services received outside of Our Service Area. For example, Emergency or Urgent Care obtained out of Our Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment or Coinsurance stated in this Contract.

Whenever you obtain covered services or supplies outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for Emergency or Urgent Care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Our Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, we may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting care in the right setting” paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by a Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.

- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply

to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs -- The term Generic Drugs means a Prescription Drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a

Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider -- A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review

and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant -** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  — Provides skilled nursing and other services on a visiting basis in the Member's home; and

  — Is responsible for supervising the delivery of such services under a plan prescribed
  and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  — Skilled nursing services

  — Prescription Drugs

  — Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;

  2. rest care;

3. extended care;
4. convalescent care;
5. care of the aged;
6. Custodial Care;
7. educational care;
8. treatment of Mental Health Disorders;
9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.
- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.
- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Summary
5/8/2014 4:09:00 PM

Differences exist between documents.

New Document:	**Old Document:**
IN_OFFHIX_HMHS(1-15)	FINAL APPROVED IN_OFFHIX_HMHS(1-14)_rev 6-19-13
108 pages (1018 KB)	108 pages (395 KB)
5/8/2014 4:08:08 PM	5/8/2014 4:07:50 PM
Used to display results.	

Get started: first change is on page 1.

No pages were deleted

How to read this report

Highlight indicates a change.
~~**Deleted**~~ indicates deleted content.
 indicates pages were changed.
 indicates pages were moved.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  - Our company and services.
  - Our network of doctors and other health care providers.
  - your rights and responsibilities.
  - the rules of your health care plan.
  - the way your health plan works.
- Make a complaint or file an appeal about:
  - your health care plan.
  - any care you get.
  - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Network

	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,600]	$[0 - 13,200]

****

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

****

The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	Copayment	Coinsurance
Tier 1 (90-day supply)	$[0 - 50]	[0 - 30]% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
**********		
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.

- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be

considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the "Member Grievances" section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Where You Can Obtain Prescription Drugs" section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
- Gastric electrical stimulation.
- Hypnotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:

- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond the Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications or other forms or statements the Plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

This section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract.

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]

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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or

- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.

- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply

to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs -- The term Generic Drugs means a Prescription Drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a

Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider -- A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review

and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant -** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  — Provides skilled nursing and other services on a visiting basis in the Member's home; and

  — Is responsible for supervising the delivery of such services under a plan prescribed
  and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  — Skilled nursing services

  — Prescription Drugs

  — Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;

  2. rest care;

3. extended care;
4. convalescent care;
5. care of the aged;
6. Custodial Care;
7. educational care;
8. treatment of Mental Health Disorders;
9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.
- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.
- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have ~~30~~10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within ~~30~~10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

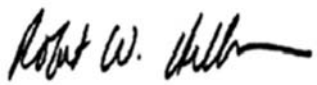
Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.



President

~~YOUR RIGHTS AND RESPONSIBILITIES~~

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member~~. You~~, you have certain rights and responsibilities ~~to help make sure that You get the most from this Plan. It helps You know what You can expect from Your overall~~when receiving your health care ~~benefit experience and become a smarter health~~. You also have a responsibility to take an active role in your care ~~consumer~~. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with ~~Your~~your doctors and other health ~~professionals~~providers about all health care options and treatment needed for ~~Your~~your condition~~.~~. This is no matter what the cost or whether it is covered under ~~this Plan~~your plan.
- Work with ~~Your~~your doctors in making choices about ~~Your~~your health care.
- Be treated with respect and dignity.
- ~~Privacy of Your~~ Expect Us to keep your personal health information~~,~~ private. This is as long as it follows state and Federal laws and ~~our~~Our privacy policies.
- Get the information ~~about our~~you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  - Our company and services~~, and our Network~~.
  - Our network of doctors and other health care ~~Providers~~providers.
- ~~Get more information about Your Rights and Responsibilities and give us Your thoughts and ideas about them.~~
  - ~~Give us Your thoughts and ideas about any of~~ your rights and responsibilities.
  - the rules of ~~this Plan and in~~ your health care plan.
  - the way ~~it~~ your health plan works.
- Make ~~complaints~~a complaint or file an appeal about~~: our organization.~~
  - your health care plan.
  - any care you get.
  - any covered service or benefit ~~or coverage decisions we make, Your coverage, or care received~~ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care ~~You~~you may get in the future~~; and~~. This includes the right to have ~~Your~~your doctor tell ~~You~~you how that may affect ~~Your~~your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of ~~Your~~your illness, ~~Your~~your treatment and what may result from ~~that illness or treatment from a doctor or other health care professional. When it seems that You will not be able to understand~~ it. If you don't understand certain information, ~~that information will be given to someone else that you~~ you can choose~~.~~ a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a ~~Network Primary Care Physician~~network primary care physician (doctor), also called a PCP, if ~~Your Plan~~your health plan requires it.
- Treat all doctors, health care ~~professionals~~providers and staff with courtesy and respect.
- Keep all scheduled appointments with ~~Your~~your health care ~~Providers and call~~providers. Call their office if ~~You have a delay~~you may be late or need to cancel.
  - ~~Read and understand, to the best of Your ability, all information about Your health benefits or ask for help if You need it.~~

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- ~~To the extent possible, understand Your~~Understand your health problems as well as you can and work with ~~Your~~your doctors or other health care ~~professionals~~providers to make a treatment plan that ~~You~~you all agree on.
- ~~Give us, Your~~Tell your doctors ~~and~~or other health care ~~professionals~~providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help ~~You~~you get the best possible care and all the benefits ~~You~~you are entitled to. This may include information about other health ~~coverage~~ and insurance benefits ~~You~~you have in addition to ~~Your~~your coverage with ~~us~~Us.
    - ~~Tell Your doctors or other health care professionals if You don't understand any care You are getting or what they want You to do as part of Your care plan.~~
    - ~~Follow the care plan that You have agreed on with your Doctors and other health care professionals.~~
    - ~~Follow all Plan rules and policies.~~
- Let ~~our customer service~~ Our Member Service department know if ~~You~~you have any changes to ~~Your~~your name, address or ~~Dependents~~family members covered under ~~Your~~your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you ~~have any questions or~~ need ~~additional~~more information~~,~~ or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call ~~customer service at~~ the ~~phone~~Member Services number on ~~the back of~~ your ID card.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for ~~deductibles~~Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law~~.~~ and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Network

	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,~~350~~660]	$[0 - ~~12,700~~13,200]
~~The most you will pay per calendar year~~	~~$[0 - 6,350]~~	~~$[0 - 12,700]~~

****

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

****

The most you will pay per calendar year	~~**Network**~~$[0 - 6,600]	$[0 - 13,200]
	~~**Copayment**~~	~~**Coinsurance**~~

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%

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	Network	
	Copayment	Coinsurance
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	
**********		
Doctor visits		
Primary Care Physician (PCP) Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits.	$[0 - 50]	[0 - 30]%
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		
**********		
Doctor visits		
Primary Care Physician (PCP) Copayment applies to PCP office visit charge only.	$[0 - 50]	[0 - 30]%
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		
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	Network	
	Copayment	Coinsurance
Doctor visits		
Primary Care Physician (PCP)	$[0 - 50]	[0 - 30]%
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 30]%
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - ~~1~~,500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		

	Network	
	Copayment	Coinsurance
Inpatient admission	$[0] - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the	$[0]	[0 - 30]%

	Network	
	Copayment	Coinsurance
limit listed here.		
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year	$[0]	[0 - 30]%
Surgery **Inpatient admission** **Outpatient treatment** **Ambulatory Surgical Center**	$[0 - ~~1~~,500] per admission $[0] $[0]	[0 - 30]% [0 - 30]% [0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	Copayment	Coinsurance
Retail (30-day supply)		
Tier 1	$[0 - ~~20~~25]	~~%~~[0 - 30]% [after Calendar Year Deductible]

Prescription Drugs	Copayment	Coinsurance
Tier 2	$[0 - ~~50~~55]	~~%~~[0 - 30]% [after Calendar Year Deductible]
Tier 3	~~$~~$[0]	~~%~~[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	~~$~~$[0]	~~%~~[0 - 30]% after Calendar Year Deductible
Mail Order ~~(90-day supply)~~		
Tier 1 (90-day supply)	$[0 - ~~40~~50]	% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - ~~125~~137.50]	~~%~~[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	~~$~~$[0]	~~%~~[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	~~Not Covered~~$[0]	~~Not Covered~~[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	

[Optional Language] **********	
**********	
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.
[Optional Language] **********	
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Pediatric Dental Services

The following dental benefits are available for Covered Services ~~received from a Network Provider for members~~for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this ~~document~~Contract for a detailed description of services.

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	~~Pediatric~~
~~**Annual Maximum per Member**~~	~~$[0]~~
~~**Annual Deductible per Member**~~	~~$[0]~~

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%

Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

~~[Optional Language]~~

~~**********~~

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	
Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This ~~plan~~Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary)	

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This ~~plan~~Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

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Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or ~~Approved~~approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to ~~medical necessity~~Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health~~/~~ and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment~~, and Benefit Limitation information~~.

Covered Services include but are not limited to:

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- **Inpatient ~~services~~** ~~– individual or group psychotherapy, psychological testing, family counseling with family members to assist in your diagnosis and treatment, convulsive therapy including electroshock treatment or convulsive drug therapy. If you or your Non-Network or BlueCard Provider do not obtain the required Precertification, as described under the "Requesting Approval for Benefits" section of this Contract, a Retrospective review will be done to determine if your care was Medically Necessary. If We determine the services you receive are not Medically Necessary under your Plan and you received your care from a BlueCard Provider or a Provider that does not have a participation agreement with Us, you will be financially responsible for the services~~**Services** – in a

Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Partial hospitalization** - an intensive, structured setting providing 3 or more hours of treatment or programming per day or evening, in a program that is available 5 days a week. The intensity of services is similar to Inpatient settings. Skilled nursing care and daily psychiatric care (and Substance Abuse care if the patient is being treated in a partial hospital Substance Abuse program) are available, and treatment is provided by a multidisciplinary team of Behavioral Health professionals.

- **Intensive Outpatient treatment or day treatment** - a structured array of treatment services, offered by practice groups or facilities to treat Behavioral Health Conditions. Intensive Outpatient Programs provide 3 hours of treatment per day, and the program is available at least 2-3 days per week. Intensive Outpatient Programs may offer group, DBT, individual, and family services.

- **Outpatient treatment, or individual or group treatment** - office-based services, for example diagnostic evaluation, counseling, psychotherapy, family therapy, and medication evaluation. The service may be provided by a licensed mental health professional and is coordinated with the psychiatrist.
  Non-Covered Behavioral Health Services (please also see the Exclusions section of this Contract for other non-Covered Services)
- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.
- **Residential Treatment** services. - which is specialized 24-hour treatment in a licensed Residential treatment meansTreatment Center. It offers individualized and intensive treatment in a residential setting, including observationand includes:
  - Observation and assessment by a psychiatrist weekly or more frequently, an individualized program of rehabilitationoften.
  - Rehabilitation, therapy, and education, and recreational or social activities..

You can get Covered Services from the following Providers:

- Psychiatrist.
- Psychologist.
- Licensed clinical social worker (L.C.S.W.).
- Mental health clinical nurse specialist.
- Licensed marriage and family therapist (L.M.F.T.).
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract.

- Custodial or Domiciliary care.
- Supervised living or halfway houses.
- Room and board charges unless the treatment provided meets our Medical Necessity criteria for Inpatient admission for your condition.

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~~We encourage you to contact Our Mental Health/Substance Abuse Services Subcontractor to verify the use of appropriate procedures, setting and Medical Necessity. When you obtain prior approval from Our Mental Health/Substance Abuse Services Subcontractor and receive services from the Provider designated by that approval, Covered Services will be considered a Network service. If you do not obtain prior approval, Covered Services will be considered a Non-Network service.~~

~~Clinical Trials~~

~~See the Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.~~

~~Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract.~~ An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or

ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

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Dental Services – Dental Care for Pediatric Members

All Covered Services are subject to the terms, limitations, and exclusions of your Contract. See your "Schedule of Benefits" for your cost share amounts, such as Deductibles and/or any Coinsurance.

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Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are medically necessaryMedically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to usUs on your claim to determine if they are a covered serviceCovered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section "Orthodontic Care" for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by usUs. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any coinsuranceCoinsurance or deductibleDeductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to usUs. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to usUs yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

Description of Covered Services for Pediatric Members

We cover the following dental care services for membersMembers up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, weWe will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations - Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

NOTE: Comprehensive oral evaluations will be covered 1 timeonce per dental office, subjectup to the 2 times-time per calendar year limitation. Any additionallimit. Additional comprehensive oral evaluations performed byfrom the same dental office will be covered as a periodic oral evaluation, and will be subject to the 2 times-time per calendar year limitationlimit will apply.

Radiographs (X-rays)

- Bitewings - Covered at – 1 series of bitewings per 6-month period.
- Full Mouth (Complete Series) – Covered 1 time – Once per 60-month period.
- Panoramic – covered 1 timeOnce per 60-month period.
- Periapical(s) - 4 single x-rays are covered per 12-).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.
- Occlusal - Covered at 2 series per 24-month period.

Interpretation of diagnostic images by a practitioner not associated with capture of the image, including report.

Dental Cleaning (Prophylaxis) – - Any combination of this procedure and Periodontal Maintenance (See or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) – Covered 2 times per 12-month periodcalendar year.

Fluoride Varnish – Covered 2 times per 12-month period for children through the age of 18calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered 1 timeonce per 3624-month period for permanent first and second molars.

Basic Restorative Services

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations (with a dentist other than dentistthe one providing treatment).

Amalgam (silver) **Restoration.Restorations -** Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations. - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

LIMITATION: Coverage for amalgam**Re-cement inlay and crown.**

Pre-fabricated or composite restorations will be limited to 1 service per**Stainless Steel Crown (primary or permanent tooth** surface per 24-month period.

Space Maintainers) - Covered 1 time per lifetime for extracted primary posterior (back) teeth60-month period through the age of 14.

Recement Space Maintainer.

Basic Extractions

- Removal of coronal remnants (retained pieces of the crown portion of the tooth) on primary teeth

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- ~~Extraction of erupted tooth or exposed root~~

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services~~.~~

- ~~Therapeutic~~Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- ~~Pulpal Therapy~~
- ~~Therapeutic Pulpotomy~~
- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

~~**LIMITATION:** All of the above procedures are covered 1 time per tooth per lifetime.~~

Other Endodontic Treatments – Limited to once per tooth per lifetime~~.~~

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance – A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed ~~previous surgical or nonsurgical~~ periodontal treatment.

~~LIMITATION: Any~~Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) ~~is covered~~are limited to 4 times per ~~calendar year~~12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care - Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root ~~planing - Covered~~planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to ~~1 time~~once per 24 months.
- Full mouth debridement ~~- Covered 1 time per lifetime~~.

Crown Lengthening ~~— Covered once per lifetime.~~

Complex Surgical Periodontal Care – Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;

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- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

~~LIMITATION:~~ Complex surgical periodontal services are limited as follows:

- Only ~~1~~one complex surgical periodontal service is covered per 36-month period per single ~~tooth~~ or multiple teeth in the same quadrant ~~and only~~ if the pocket depth of the tooth is 5 millimeters or greater.

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Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

~~LIMITATION:~~ Surgical removal of ~~3rd~~third molars ~~is~~are only covered if the removal is associated with symptoms ~~or~~of oral pathology.

Other Complex Surgical Procedures

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- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

~~LIMITATION: The above procedures are covered only when required to prepare for dentures and is a benefit covered once in a 60-month period.~~

Other Oral Surgery Procedures~~:~~

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- Incision and drainage of abscess (intraoral soft tissue)
- ~~Collect – apply~~Collection and application of autologous product
- Excision ~~or~~of pericoronal ~~gingival~~ gingiva
- Coronectomy
- Tooth reimplantation ~~–~~of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

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- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia ~~– Covered only when given with covered complex surgical services.~~

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Major Restorative Services

Inlays ~~-~~ Benefit ~~will~~shall equal an amalgam (silver) restoration for the same number of surfaces.

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~~LIMITATION:~~ If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the ~~maximum~~

~~allowed amount~~Maximum Allowed Amount for the ~~amalgam restoration~~Covered Service and ~~the~~ inlay, plus any ~~deductible~~Deductible, Copayment, and/or ~~coverage percentage~~Coinsurance that applies.

~~**Pre-fabricated or Stainless Steel Crown** - Covered 1 time per 60-month period.~~

Onlays and/or Permanent Crowns ~~-~~ Covered ~~1 time per 5 years~~once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only.

~~LIMITATION:~~ We will pay up to the ~~maximum allowed amount~~Maximum Allowed Amount for a porcelain to noble metal crown.~~-~~ You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any ~~deductible~~Deductible and/or ~~coverage percentage that applies~~Coinsurance.

Implant Crowns ~~-~~ See "Prosthodontic Services~~.~~".

Recement Inlay, Onlay, and Crowns ~~-~~ Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair ~~- Covered 1 time per 12-month period per tooth when the submitted narrative from the treating dentist supports the procedure~~Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface ~~-~~ Covered ~~1 time per 5 years~~once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

~~**Resin infiltration/smooth surface.**~~

Prefabricated post and core in addition to crown ~~– covered 1~~Covered once per tooth every 60 months.

Occlusal ~~Guards –~~guards Covered ~~1 per~~once every 12 months for ~~members~~Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning ~~– Covered 1 time per 24-month period.~~

Reline and Rebase ~~–~~ Covered ~~1 time~~once per 36-month period when:

- ~~When the~~The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- ~~Only after~~At least 6 months ~~following~~have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) ~~-~~ Covered ~~1 time per 12 month period~~when:

- ~~When the~~The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- ~~Only after~~At least 6 months ~~following~~have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments ~~-~~ Covered ~~2 times per 12-month period~~when:

- ~~When the~~The denture is the permanent prosthetic appliance; and
- ~~Only after~~At least 6 months ~~following~~have passed since the initial placement of the denture.

Partial and Bridge Adjustments ~~-~~ Covered ~~2 times per 24-month period~~when:

- ~~When the~~The partial or bridge is the permanent prosthetic appliance; and
- ~~Only after~~At least 6 months ~~following~~have passed since the initial placement of the partial or bridge.

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Removable Prosthetic Services (Dentures and Partials) ~~-~~ Covered ~~1 time per 5 year period~~once every 60 months:

- For ~~covered persons~~Members age 16 ~~or older~~through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have ~~elapsed~~passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) ~~-~~ Covered ~~1 time per 5 year period~~once every 60 months:

- For ~~covered persons~~Members age 16 ~~or older~~through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have ~~elapsed~~passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

~~LIMITATION:~~ If there are multiple missing teeth, benefits may only be paid for a removable partial denture ~~may be the benefit since~~if it would be the least costly, commonly performed course of treatment. ~~The~~Any optional ~~benefit is~~benefits are subject to all contract ~~limitations~~limits on the ~~covered service~~Covered Service.

Recement Fixed Prosthetic ~~- Covered 1 time per 12 months.~~.

Single Tooth Implant Body, Abutment and Crown ~~-~~ Covered ~~1 time~~once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

~~LIMITATION:~~ Some adjunctive implant services may not be covered. ~~It is recommended~~We recommend that you get a pretreatment estimate ~~be requested~~ to estimate the amount of payment ~~prior to beginning~~before you begin treatment.

Orthodontic Care

Orthodontic ~~Treatment~~care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover ~~orthodontic care that is Dentally Necessary Orthodontic Care. You should submit your treatment plan to us before you start any orthodontic treatment to make sure it is covered under this Contract~~Dentally Necessary orthodontic care.

~~Dentally Necessary Orthodontic Care~~

To be considered Dentally Necessary ~~Orthodontic Care,~~ at least one of the following ~~criteria~~ must be present:

a~~)~~. There is spacing between adjacent teeth which interferes with the biting function;
b~~)~~. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c~~)~~. Positioning of the jaws or teeth impair ~~-~~chewing or biting function;
d~~)~~. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e~~)~~. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

~~Orthodontic~~

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

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Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts~~/~~ / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures ~~– surgical~~ Surgical exposure of impacted or unerupted tooth for orthodontic reasons~~;~~ or surgical repositioning of teeth.

~~**Note:**~~ Treatment that is already in progress ~~(~~with appliances placed ~~prior to being~~before you were covered ~~under~~by this ~~Contract)~~Plan will be ~~benefited~~covered on a pro-rated basis.

~~Orthodontic Exclusions~~

~~Coverage is NOT provided for:~~

~~•~~Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
~~•~~2) Repair or replacement of lost/broken/stolen appliances;
~~•~~3) Orthodontic retention/retainer as a separate service;
~~•~~4) Retreatment and/or services for any treatment due to relapse;
~~•~~5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
~~•~~6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of ~~your~~ treatment. ~~-~~ You must ~~have continuous coverage~~continue to be eligible under ~~this plan~~the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: ~~-~~(1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating ~~dentist~~orthodontist should ~~submit~~send a pre-treatment estimate to us. ~~-~~An Estimate of Benefits form will be sent to you and your ~~dentist~~orthodontist indicating the estimated ~~maximum allowed amount~~Maximum Allowed Amount, including any amount ~~(coinsurance)~~ you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the ~~dentist~~orthodontist should ~~submit~~send the Estimate of Benefit form with the date of appliance placement and his/her signature. ~~-~~After we have verified your Plan benefit and your eligibility ~~verification by us~~, a benefit payment will be issued. ~~-~~A new/revised Estimate of Benefits form will also be ~~issued~~sent to you and your ~~dentist.~~ orthodontist. This again ~~will serve~~serves as the claim form to be ~~submitted~~sent in 6 months ~~from~~after the ~~date of appliance placement~~appliances are placed.

~~[Optional Language]~~

~~**********~~

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

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Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency ~~medical conditions~~Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency ~~medical condition~~Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.

- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those ~~covered services~~Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional ~~covered services~~Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional ~~covered services~~Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when ~~Medically Necessary to safeguard the mother's health or in case of rape or incest~~a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:
  1) Allergy serum extracts;
  2) Chem strips, Glucometer, and lancets;
  3) Clinitest;

4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1) Replace all or part of a missing body part and its adjoining tissues; or
2) Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
5) Intraocular lens implantation for the treatment of cataract or aphakia. ~~Contract~~Contact lenses or glasses are often prescribed following lens implantation
and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
7) Cochlear implants.
8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
9) Restoration prosthesis (composite facial prosthesis).
10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

Non-covered Prosthetic appliances include but are not limited to:

1) Dentures, replacing teeth or structures directly supporting teeth;
2) Dental appliances;
3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
  2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled "Behavioral Health Services" for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

~~Autism Spectrum Disorders~~

~~Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the~~ America Psychiatric Association. ~~Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.~~

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled "Preventive Care Services", "Maternity Services", and "Home Care Services", for services covered by the Plan. For Emergency Care, refer to the "Emergency Care and Urgent Care" section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

~~**********~~

~~Online Visits~~

When available in your area, ~~you~~your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

~~[Optional Language]~~

~~**********~~

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your ~~copayment, coinsurance~~Copayment, Coinsurance and ~~deductible~~Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at ~~our~~Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy ~~benefits manager~~Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy ~~benefits manager~~Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a ~~formulary~~Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by ~~us~~Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by ~~our~~Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at ~~our~~Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your ~~Benefit Program~~Contract limits Prescription Drug coverage to those Drugs listed on ~~our~~Our Prescription Drug List. This ~~formulary~~Formulary contains a limited number of ~~prescription drugs~~Prescription Drugs, and may be different than the ~~formulary~~Formulary for other Anthem products. Generally, it includes select ~~generic drugs~~Generic Drugs with limited ~~brand prescription drugs~~Brand

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Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete ~~prescription drugs~~Prescription Drugs from this ~~formulary~~Formulary from time to time. A description of the ~~prescription drugs~~Prescription Drugs that are listed on this ~~formulary~~Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription ~~Legend~~ Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; ~~Certain~~certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your ~~Benefit Program~~Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in ~~our~~Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain ~~prescription drugs~~Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to ~~us~~Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

~~Mail Order~~

Your Mail Order Prescription Drug program is administered by ~~Anthem BCBS's~~Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (~~maintenance medication~~Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem ~~BCBS~~ does not dispense Drugs or fill Prescriptions.

Refer to your ~~Summary of~~Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain ~~prescription drugs~~Prescription Drugs.

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Helpful Tip: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

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You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your ~~specialty~~Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get ~~prior authorization.~~Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your ~~specialty drug~~Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your ~~deductible~~Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing ~~our~~Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program

2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, ~~we~~We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and ~~medically necessary.~~Medically Necessary. You may have to pay the applicable Copayment/~~coinsurance~~Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is ~~medically necessary~~Medically Necessary for you to have the drug immediately, ~~we~~We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a ~~participating pharmacy~~Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional ~~coinsurance~~Coinsurance.

Important Details About Prescription Drug Coverage

Your ~~Benefit Program~~Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before ~~we~~We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of ~~our~~Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details ~~we~~We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require ~~prior authorization.~~Prior Authorization. Also, a Participating Pharmacist can help arrange ~~prior authorization~~Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, ~~we~~We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details ~~we~~We need to decide if ~~prior authorization~~Prior Authorization should be given. We will give the results of ~~our~~Our decision to both you and your Provider.

If ~~prior authorization~~Prior Authorization is denied you have the right to file a Grievance as outlined in the "~~Grievance and External Review Procedures~~Member Grievances" section of this Contract.

For a list of Drugs that need ~~prior authorization~~Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your ~~Benefit Program.~~Contract. Your Provider may check with ~~us~~Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which ~~brand~~Brand Name or ~~generic~~Generic Drugs are covered under the ~~Benefit Program~~Contract.

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Step Therapy

Step therapy is a process in which you may need to use one type of Drug before ~~we~~We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your ~~Benefit Program~~Contract also covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "~~Benefit at a Retail or Home Delivery (Mail Order) Pharmacy~~Where You Can Obtain Prescription Drugs" section.

> **Helpful tip**: When Prescription Drugs are covered under this benefit, they will not also be covered under the "~~Benefit at a Retail or Home Delivery (Mail Order) Pharmacy~~Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the ~~Benefit at a Retail or Home Delivery (Mail Order) Pharmacy~~"Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on ~~our~~Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time ~~we~~We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, ~~we~~We may allow access to network rates for drugs not listed on ~~our formulary~~Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210

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Home Office Address You may visit ~~our~~Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;
    - Type 2 Diabetes Mellitus;
    - Cholesterol;
    - Child or Adult obesity.
2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic ~~drugs~~Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand ~~name~~Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per ~~calendar year, or as required by law~~pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact ~~us~~Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and

- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns

(feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day,

two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

~~Donor benefits are limited to benefits not available to the donor from any other source.~~

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by ~~a~~ an in-Network Transplant Provider Facility. Services received from ~~a Non~~an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by ~~a~~ an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-~~-~~up services at ~~a~~ an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant ~~workup~~work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

~~The above services~~Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Helpful tip: See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

~~**Vision Care that is Covered**~~:

~~The following services or supplies are covered vision services. We will only cover vision care that is listed in this section. See your Schedule of Benefits for the limitations and your cost share amounts for covered vision care. We will not pay for vision care listed in the "Vision Care that is not Covered" section.~~

~~**Pediatric Vision Care (applies to Members under age 19)**~~

~~The following vision care benefits are available only for Members through the age of 19.~~

Pediatric Eye Exam

This ~~Benefit Program~~Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together. ~~The exam may include the following:~~

- ~~Case History~~
- ~~Cover test~~
- ~~Ocular Motility~~
- ~~Neurological Integrity~~
- ~~External Exam~~
- ~~Internal Exam~~
- ~~Retinoscopy~~
- ~~Phorometry testing~~
- ~~Point refraction~~
- ~~Tonometry~~
- ~~Opthalmoscopic exam~~
- ~~Confrontation Visual Fields~~
- ~~Biomicroscopy~~
- ~~Color Vision Testing~~
- ~~Diagnosis/Prognosis~~
- ~~Recommendations~~

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this ~~Benefit Program. Lens options include choice of plastic or polycarbonate~~Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- ~~lenticular~~progressive

~~The following lens options are also available at an additional cost. See your Schedule of Benefits for more information on your cost share amount.~~

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- ~~Ultraviolet Protective Coating~~
- ~~Blended Segment~~
- ~~Intermediate Vision~~
- ~~Standard Progressives~~
- ~~Premium Progressives~~
- ~~Photochromic~~
- ~~Polarized~~
- ~~Standard Anti-Reflective Coating~~
- ~~Premium Anti-Reflective Coating~~
- ~~Hi-Index~~

Frames (formulary)

~~This Benefit Program offers a~~ A selection of frames ~~that are~~is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

~~Contact Lens Professional Fitting Fees~~

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

~~**Low Vision Benefits**~~

- ~~Comprehensive Low Vision Exam~~
- ~~Optical/Non-optical aids~~
- ~~Supplemental testing~~

~~**Vision Care that is NOT Covered:**~~

~~We will not pay for services incurred for, or in connection with, any of the items below.~~

- ~~For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.~~
- ~~To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.~~
- ~~For which the Member has no legal obligation to pay in the absence of this or like coverage.~~
- ~~Prescribed, ordered or referred by, or received from a Member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.~~
- ~~For completion of claim forms or charges for medical records or reports unless otherwise required by law.~~
- ~~For missed or canceled appointments.~~

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- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Subscriber Agreement or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Subscriber Agreement.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

Note: Please refer to the Schedule of Benefits for the appropriate Cost-Shares and limitations.

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NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that ~~result~~results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

- ~~Care provided or billed by residential treatment centers or facilities, unless those centers or facilities are required to be covered under state law. This includes but is not limited to individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.~~
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, ~~residential programs for drug and alcohol,~~ or outward bound programs~~, even if psychotherapy is included~~.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if ~~we~~We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as

otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the “Covered Services” section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage’s benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;

- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug ~~addictin~~addiction or drug dependency~~, Methadone maintenance program~~, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
- Gastric electrical stimulation.
- Hypnotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or

- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

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90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:

- Administration Charges: ~~Are charges~~Charges for the administration of any Drug except for covered immunizations as approved by ~~us~~Us or the Pharmacy Benefits Manager ~~(~~PBM~~:~~).
- Clinically-Equivalent Alternatives~~:~~ Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.
- Compound Drugs ~~unless there is at least one ingredient that you need a prescription for, and the Drug is not essentially a copy of a commercially available drug product.~~
- Contrary to Approved Medical and Professional Standards~~:~~ Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility~~:~~ Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by ~~us~~Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME~~)~~)~~:~~ Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies~~,~~~~:~~ Oral immunizations and biologicals, even if they are federal ~~legend~~Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs~~:~~ Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service~~:~~ Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless ~~we~~We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when ~~we~~We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items~~:~~ Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.

- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

~~91)~~ 92) Your Vision care services do not include:

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- Vision care for ~~members~~Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- ~~For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a member receives the benefits in whole or in part. This exclusion also applies whether or not the member claims the benefits or compensation. It also applies whether or not the member recovers from any third party.~~
- ~~To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.~~
- ~~For which the member has no legal obligation to pay in the absence of this or like coverage.~~
- Prescribed, ordered or referred by, or received from a member of the ~~member's~~Member's immediate family, including the ~~member's~~Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this ~~booklet~~Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- ~~For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.~~
- ~~Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network provider).~~
- ~~For safety glasses and accompanying frames.~~
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this ~~Contract~~Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).

- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this ContractPlan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements. Lost or broken lenses or frames, unless the member has reached the member's normal interval for service when seeking replacements.

- For services or supplies not specifically listed in this ContractPlan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

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92293) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for membersMembers age 19 and older.
- Dental services which a member would be entitled to receive for a nominal charge or without charge if this coverage were not in force under any Worker's Compensation Law, Federal Medicare program, or Federal Veteran's Administration program. However, if a member receives a bill or direct charge for dental services under any governmental program, then this exclusion shall not apply. Benefits under this Contract will not be reduced or denied because dental services are rendered to a subscriber or dependent who is eligible for or receiving medical assistancenot listed as covered in this Contract.
- Dental services or health care services not specifically covered under the Contract (including any hospital charges, prescription drug charges and dental services or supplies that are medical in nature).
- New, experimental or investigational dental techniques or services may be denied until there is, to our satisfaction, an established scientific basis for recommendation.
- Dental services completed prior to the date the member became eligible for coverage.
- Services of anesthesiologists.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Dental services performed other than by a licensed dentist, licensed physician, his or her employees.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Oral hygiene instructions.

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- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- ~~Case presentations.~~
- ~~Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).~~
- ~~Athletic mouth guards, enamel microabraision and odontoplasty.~~
- ~~Retreatment or additional treatment necessary to correct or relieve the results of treatment previously benefited under the Contract.~~
- ~~Bacteriologic tests. Please refer to your medical coverage to determine if this is a covered medical benefit.~~
- ~~Cytology sample collection. Please refer to your medical coverage to determine if this is a covered medical benefit.~~
- ~~Separate services billed when they are an inherent component of another covered service.~~
- ~~Services for the replacement of an existing partial denture with a bridge.~~
- ~~Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.~~
- ~~Provisional splinting, temporary procedures or interim stabilization.~~
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- ~~Services or supplies that are medical in nature, including dental oral surgery services performed in a hospital. Please refer to your medical coverage to determine if this is a covered medical benefit.~~
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment~~Incomplete root canals.~~
- ~~Cone beam images.~~
- ~~Anatomical crown exposure.~~
- ~~Temporary anchorage devices.~~
- ~~Sinus augmentation.~~
- ~~Amalgam or composite restorations, inlays, onlays and/or crowns placed for preventive~~ or ~~cosmetic purposes.~~
- ~~Temporomandibular Joint Disorder (TMJ) except as~~additional treatment necessary to correct or relieve the results of treatment previously covered under ~~your medical coverage.~~
- ~~Oral hygiene instructions.~~
- ~~Repair or replacement of lost/broken appliances are not a covered benefit~~the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.

- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.

~~[Optional Language]~~

~~**********~~- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP~~.~~;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
~~3~~4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
4~~5~~) Be a resident of the State of Indiana; and meet the following applicable residency standards;

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution
- Be capable of indicating intent
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution
- Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
- Not be emancipated
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner. - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends ~~on~~at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including ~~natural children,~~ stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is ~~filed~~awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance ~~payments~~Payments of the ~~premium tax credit~~Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for ~~Loss~~loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

~~7)~~• Individual who no longer resides, lives or works in the Plan's Service Area,

~~• A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits,~~

- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
- Termination of employer contributions, and
- Exhaustion of COBRA benefits.

Effective dates ~~of Loss~~for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay ~~premiums~~Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

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The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services. Acceptance of ~~payments~~Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

~~A Member's coverage terminates on the date such Member ceases to be eligible for coverage. The Plan has the right to bill the Subscriber for the cost of any services provided to such person during the period such person was not eligible under the Subscriber's coverage.~~

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card ~~for each Member~~ and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
~~2~~1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
~~3~~2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered ~~Dependent~~Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. ~~Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of~~ We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material ~~fact~~information relating to claims or if you knowingly participate in or permit fraud or deception by ~~a Member may result in~~ any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination ~~or rescission of~~ is mailed. We will also terminate your Dependent's coverage~~.~~, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services.

~~This Contract may also be terminated if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination for any act, practice or omission that constitutes fraud or any intentional misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give you at least 30 days written notice prior to rescission of this Contract.~~ After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

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Discontinuation of Health Coverage

We can refuse to renew your Contract if ~~we~~We decide to discontinue a health coverage product that We offer in the individual market. If ~~we~~We discontinue a health coverage product, ~~we~~We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any

health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required ~~premium~~Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's ~~premium~~Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the ~~latter of the~~ last day of the first month of the 3-month grace period ~~or the last day through which Premium is paid~~. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the ~~date through which Premium is paid~~last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of ~~30~~31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. ~~-~~ If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day ~~of the grace period.~~ through which Premium is paid. You will be liable to Us for ~~the Premium payment due including those for the grace period. You will also be liable to Us for~~ any claims payments made for services incurred after the ~~grace period~~date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the ~~Member~~former Members cannot reapply until the next annual open enrollment period unless ~~there is~~they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

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Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

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~~Certification of Prior Creditable Coverage~~

~~If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under this Contract. You may need the document to buy, for yourself or your family, other health coverage. Certifications may be requested within 24 months of losing coverage.~~

~~You may also request a certification be provided to you at any other time, even if you have not lost coverage under this plan. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card.~~

~~[Optional Language]~~

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HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "~~Complaints and Appeals~~Member Grievances" section of this ~~Certificate~~Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this ~~Certificate~~Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;

- Out-of-area urgent care; or
- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in ~~our~~Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with ~~us~~Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this ~~Certificate~~Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this ~~Certificate~~Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This ~~Certificate~~Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and ~~our~~Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this ~~Certificate~~Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with ~~members~~Members and are solely responsible to ~~members~~Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this ~~Certificate~~Contract has the right to services or benefits under this ~~Certificate~~Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this ~~Certificate~~Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this ~~Subscriber Agreement~~Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your ~~Benefit Program~~Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your ~~Benefit Program~~Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

Generally, services received from ~~an~~a Non-Network Provider under this ~~Subscriber Agreement~~Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by ~~us~~Us. When you receive Covered Services from ~~an~~a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, ~~we~~We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect ~~our~~Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means ~~we~~We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, ~~we~~We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

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A Participating Provider is a Provider who is in the managed network for this specific ~~Benefit Program~~Contract or in a special center of excellence/or other closely managed specialty network~~, or who has a participation contract with us.~~. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit ~~our~~Our website at www.anthem.com.

Providers who have not signed any contract with ~~us~~Us and are not in any of ~~our~~Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which ~~we~~We have established in Our discretion, and which ~~we~~We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers~~, reimbursement amounts for like/similar Providers,~~ contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by ~~us~~Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered ~~non-participating. The~~Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining ~~the~~this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your ~~out~~ Out-~~of pocket~~-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

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For certain Covered Services and depending on your ~~Benefit Program~~Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. ~~Both~~Non-Covered Services include services specifically excluded from coverage by the terms of your ~~Benefit Program~~Contract, and ~~those~~services received after benefits have been exhausted ~~are non-Covered Services.~~. Benefits may be exhausted by exceeding, for example, your day/visit limits~~.~~

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

~~The Family Deductible is an aggregate Deductible. This means that each family Member may contribute up to his/her individual Deductible amount toward Covered Services to satisfy the Family Deductible. Once two or more Members' allowable charges combine to equal the Family deductible, then no other Individual Deductible needs to be met for the calendar year. No one person can contribute more than his/her Individual Deductible to the aggregate Family Deductible. The Deductible applies to all Covered Services with a Coinsurance, except for the following:~~

- ~~The~~ Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

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Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

~~The Family Out-of-Pocket Limit accrual is an aggregate Out-of-Pocket Limit. Once two or more Members' allowable charges that are applied to their individual out-of-pocket amount combine to equal the aggregate Out-of-Pocket Limit, then no other individual out-of-pocket maximum needs to be met for the calendar year. However, no one person can contribute more than the individual Out-of-Pocket Limit to the aggregate Out-of-Pocket Limit.~~

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the ~~Member and/or family~~ Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the ~~Member and/or family for the~~ remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to ~~all~~most Covered Services even those with a zero percent Coinsurance~~, except for~~. An example of services not subject to the ~~following:~~

- Deductible is Network Preventive Care Services required by law.

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Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If ~~we~~We authorize a Network cost share amount to apply to Covered Service ~~so that you are responsible for the~~ received from a Non-Network/Non-Participating ~~Cost-Share amounts~~Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your ~~Local~~local Network ~~Area~~area. You contact Anthem in advance of receiving any Covered Services, and ~~we~~We authorize You to go to an available Non-Participating Provider for that Covered Service and ~~we~~We agree that the ~~network~~Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because ~~we~~We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which ~~we~~We provide benefits under this Contract. We also reserve the right to make payments directly to you.

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You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, ~~we~~We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for

those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment ~~we~~We would make if ~~we~~We were paying a non-participating Provider inside of ~~our~~Our Service Area. This could happen when the Host Blue's payment for the service would be more than ~~our~~Our payment for the service. Also, at ~~our~~Our discretion, ~~we~~We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact ~~us~~Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell ~~us~~Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which ~~we~~We have a related clinical coverage guideline and are typically initiated by ~~us~~Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with ~~us~~Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an Network Provider	**Services given by a BlueCard/Non-Network/ Non-Participating Provider**
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell ~~us~~Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use ~~our~~Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make ~~our~~Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any ~~medically necessary~~Medically Necessary determination, as decided solely by ~~us~~Us, notwithstanding that it might otherwise be found to be ~~investigational~~investigative as that term is defined in the Plan otherwise~~.~~. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which ~~we~~We based ~~our~~Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, ~~we~~We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, ~~we~~We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make ~~our~~Our decision, ~~we~~We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If ~~we~~We do not get the specific information ~~we~~We need or if the information is not complete by the timeframe identified in the written notice, ~~we~~We will make a decision based upon the information ~~we~~We have.

We will give notice of ~~our~~Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management ~~helps~~programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary~~. These programs are given at no extra cost to you.~~ and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers~~.~~

In addition, ~~we~~We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, ~~we~~We may provide benefits for alternate care that is not listed as a Covered Service through ~~our~~Our Case Management program.~~-~~ We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make ~~our~~Our decision case-by-case, if in ~~our~~Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate ~~us~~Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, ~~we~~We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's ~~appeal~~Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the ~~appeal~~Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard ~~appeal~~Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or

- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by ~~us~~Us or an agent of Ours regarding a service proposed by your treating Provider~~:~~:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or
    - a determination that a proposed service is Experimental/Investigational; or
2. Your Appeal is regarding ~~our~~Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one year after ~~You~~you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

~~If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.~~

If you do not agree with ~~our~~Our decision, you are entitled to request an independent, external review within one year of ~~our~~Our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714 with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your provider; you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review ~~our~~Our decision. If your claim was denied as not ~~medically necessary~~Medically Necessary or ~~experimental/investigative~~Experimental/Investigative, OPM will seek the binding opinion of an independent review organization (IRO). The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. ~~–~~The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. ~~-~~If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn ~~our~~Our decision, ~~we~~We will provide coverage or payment for your health care item or service and We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714 at any time. Additionally, the State of Indiana Department of Insurance may be able to help you file your appeal. Contact the Consumer Services Division of the Department of Insurance at (800) 622-4461 or (317) 232-2395, write to them at State of Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204 or electronically at www.ingov/idoi.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us ~~after the end of the~~ within 180 calendar ~~year plus 12 months have passed since the incident leading to your Grievance.~~days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days ~~after~~from the date you ~~are notified~~receive notice of ~~our~~the decision concerning your Grievance. ~~-~~ We will accept External Grievance requests filed within ~~one year~~120 days after you are notified of ~~our~~Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

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Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to ~~Anthem Blue Cross and Blue Shield / Blue View Vision, Attn: Grievance Department, 555 Middle Creek Parkway, Colorado Springs, CO 80921.~~:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and ~~You~~you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by ~~You~~you and any and all statements made to ~~You~~you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among ~~state~~State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by ~~state~~State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or ~~state~~State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the ~~state~~State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain

any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of ~~[25~~$[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums

have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges ~~his or her~~its understanding ~~that~~ this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), ~~and that Anthem~~which is an independent corporation ~~licensed to use the~~operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield ~~names~~

~~and marks~~Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana~~. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is~~ , and that Anthem is not contracting as the agent of the ~~Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee.~~Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

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Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

- ~~**Mental Health Condition** - A display of mental or nervous symptoms that are not a result of any physical or biological cause(s) or disorder(s).~~
- ~~**Substance Abuse** - A condition that develops when an individual uses alcohol or other drug(s) in a way that damages their health and/or causes them to lose control of their actions.~~

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database~~.~~.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay ~~coinsurance~~Coinsurance plus any ~~deductibles~~Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your ~~deductible~~Deductible, your ~~coinsurance~~Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

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Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible ~~or Out-of-Pocket Limit~~.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;

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- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your ~~deductible~~Deductible is $1000, your plan won't pay anything until you've met your $1000 ~~deductible~~Deductible for covered health care services subject to the ~~deductible~~Deductible. The ~~deductible~~Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

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2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

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Experimental/Investigative ~~–~~ A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance ~~–~~ Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage ~~–~~ Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem ~~BCBS~~ in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem ~~BCBS~~ in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This ~~formulary~~Formulary contains a limited number of prescription drugs, and may be different than the ~~formulary~~Formulary for other Anthem ~~BCBS~~ products. Generally, it includes select ~~generic drugs~~Generic Drugs with limited ~~brand~~Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem ~~BCBS~~. We may add or delete prescription drugs from this ~~formulary~~Formulary from time to time. A description of the prescription drugs that are listed on this ~~formulary~~Formulary is available upon request and at www.anthem.com

Generic Drugs ~~–~~ The term ~~Prescription~~Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs

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have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – ~~Medications~~A Drug you take on a regular~~, recurring~~ basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

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Mental Health ~~Conditions (including~~and Substance Abuse~~) - See~~ – is a condition that is listed in the ~~Behavioral Health section~~current edition of the ~~Contract.~~Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage ~~–~~ The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider ~~–~~ A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology ~~–~~ The first release of the ~~brand name~~Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider ~~–~~ A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy ~~–~~ Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility ~~–~~ Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or

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- All Covered Transplant Procedures.

Non-Participating Pharmacy ~~–~~ – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem ~~BCBS~~ at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out ~~-~~of ~~-~~Pocket Limit ~~–~~ – A specified dollar amount of expense incurred ~~by a Member and/or family~~ for Covered Services in a ~~Benefit Period~~calendar year as listed ~~on~~in the ~~Schedule~~Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached ~~for a Member and/or family, then,~~ no additional ~~Deductibles and~~ Deductible or Coinsurance ~~are~~is required ~~for that person and/or family~~ unless otherwise specified in this Contract ~~and/or the Schedule of Benefits~~.

Outpatient ~~–~~ – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy ~~–~~ – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem ~~BCBS~~ at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem ~~BCBS~~ products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy ~~–~~ – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee ~~–~~ – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process ~~–~~ – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the ~~formulary~~Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year ~~–~~ – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium ~~–~~ – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug~~)~~) – The term Prescription Drug means a ~~-~~ medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

~~**Prescription Legend Drug** -- A medicinal substance, dispensed for Outpatient use, which under the Federal Food, Drug & Cosmetic Act is required to bear on its original packing label, "Caution: Federal law~~

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~~prohibits dispensing without a prescription." Compounded medications which contain at least one such medicinal substance are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Contract.~~

Prescription Order ~~---~~ A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization ~~---~~ The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider ~~---~~ A ~~duly~~professional or Facility licensed ~~person or facility~~ by law that ~~provides~~gives health care services within the scope of ~~an applicable~~ that license and is ~~a person or facility that the Plan approves.~~ approved by Us. This includes any Provider ~~rendering services which are required by applicable~~that state law ~~to be covered~~says We must cover when ~~rendered by such Provider.~~ they give you services that state law says We must cover. Providers ~~include, but are not limited to, the persons and facilities listed below~~that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not ~~shown below,~~described in this Contract please call the number on the back of your ~~ID~~Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
  - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
  - Surgery;
  - Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** ~~---~~ A facility Provider, with an organized staff of Physicians that:
  - Is licensed as such, where required;
  - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  - Does not provide Inpatient accommodations; and
  - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Birthing Center** ~~---~~ a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
  1. constituted, licensed, and operated as set forth in the laws that apply;
  2. equipped to provide low-risk maternity care;
  3. adequately staffed with qualified personnel who:

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a. provide care at childbirth;

b. are practicing within the scope of their training and experience; and

c. are licensed if required; and

4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner** – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife** – When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** – Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant** – A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor** – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility** – A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** – A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  — Provides skilled nursing and other services on a visiting basis in the Member's home; and

  — Is responsible for supervising the delivery of such services under a plan prescribed
  and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  — Skilled nursing services

  — Prescription Drugs

  — Medical supplies and appliances

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in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** – A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** – A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;
  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;
  2. rest care;
  3. extended care;
  4. convalescent care;
  5. care of the aged;
  6. Custodial Care;
  7. educational care;
  8. treatment of Mental Health Disorders;
  9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical)** – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist** – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that

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the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy** ~~–~~ – An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist** ~~–~~ – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician** ~~–~~ –

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse** ~~- A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.~~

- ~~**Registered Nurse First Assistant -**~~ – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner** ~~–~~ – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous

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nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified)** – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** – A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center** – A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any "☐☐Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

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Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs ~~and mental health/behavioral health and substance abuse services.~~ . Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

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Tier One Drugs ~~- The term Tier One Drugs, means drugs that have the lowest Coinsurance or Copayment. –~~ This tier ~~contains~~includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs ~~- The term Tier Two Drugs, means drugs have a higher Coinsurance or Copayment than those in Tier 1. –~~ This tier ~~contains~~includes preferred Drugs ~~that may be~~considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs ~~- The term Tier Three Drugs, means drugs have a higher Coinsurance or Copayment than those in Tier 2. –~~ This tier ~~contains high cost Drugs. This~~ includes Drugs considered Generic Drugs, single source Brand Name Drugs, ~~and~~or multi-source Brand ~~Drugs. This tier also contains Specialty~~Name Drugs.

Tier Four Drugs ~~- –~~ This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

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Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page		of	
Specialist Visit	See Page		of	
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page		of	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page		of	
Outpatient Surgery Physician/Surgical Services	See Page		of	
Hospice Services	See Page		of	
Private-Duty Nursing	See Page		of	
Urgent Care Centers or Facilities	See Page		of	
Home Health Care Services	See Page		of	
Emergency Room Services	See Page		of	
Emergency Transportation/Ambulance	See Page		of	
Inpatient Hospital Services (e.g., Hospital Stay)	See Page		of	
Inpatient Physician and Surgical Services	See Page		of	
Skilled Nursing Facility	See Page		of	
Prenatal and Postnatal Care	See Page		of	
Delivery and All Inpatient Services for Maternity Care	See Page		of	
Mental/Behavioral Health Outpatient Services	See Page		of	
Mental/Behavioral Health Inpatient Services	See Page		of	
Substance Abuse Disorder Outpatient Services	See Page		of	
Substance Abuse Disorder Inpatient Services	See Page		of	
Generic Drugs	See Page		of	
Preferred Brand Drugs	See Page		of	
Non-Preferred Brand Drugs	See Page		of	
Specialty Drugs	See Page		of	
Outpatient Rehabilitation Services	See Page		of	
Habilitation Services	See Page		of	
Chiropractic Care	See Page		of	
Durable Medical Equipment	See Page		of	
Imaging (CT/PET Scans, MRIs)	See Page		of	
Preventive Care/Screening/Immunization	See Page		of	

Routine Eye Exam for Children	See Page		of	
Eye Glasses for Children	See Page		of	
Dental Check-Up for Children	See Page		of	
Rehabilitative Speech Therapy	See Page		of	
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page		of	
Well Baby Visits and Care	See Page		of	
Laboratory Outpatient and Professional Services	See Page		of	
X-rays and Diagnostic Imaging	See Page		of	
Basic Dental Care – Child	See Page		of	
Orthodontia – Child	See Page		of	
Major Dental Care – Child	See Page		of	
Transplant	See Page		of	
Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
Nutritional Counseling	See Page		of	
Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

I, on behalf of _____hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by_____ for review and approval.

_____ _____ _____

Name: Title: Date:

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Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
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Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

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Name: Title: Date:

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Outpatient Surgery Physician/Surgical Services	See Page		of	
Hospice Services	See Page		of	
Private-Duty Nursing	See Page		of	
Urgent Care Centers or Facilities	See Page		of	
Home Health Care Services	See Page		of	
Emergency Room Services	See Page		of	
Emergency Transportation/Ambulance	See Page		of	
Inpatient Hospital Services (e.g., Hospital Stay)	See Page		of	
Inpatient Physician and Surgical Services	See Page		of	
Skilled Nursing Facility	See Page		of	
Prenatal and Postnatal Care	See Page		of	
Delivery and All Inpatient Services for Maternity Care	See Page		of	
Mental/Behavioral Health Outpatient Services	See Page		of	
Mental/Behavioral Health Inpatient Services	See Page		of	
Substance Abuse Disorder Outpatient Services	See Page		of	
Substance Abuse Disorder Inpatient Services	See Page		of	
Generic Drugs	See Page		of	
Preferred Brand Drugs	See Page		of	
Non-Preferred Brand Drugs	See Page		of	
Specialty Drugs	See Page		of	
Outpatient Rehabilitation Services	See Page		of	
Habilitation Services	See Page		of	
Chiropractic Care	See Page		of	
Durable Medical Equipment	See Page		of	
Imaging (CT/PET Scans, MRIs)	See Page		of	
Preventive Care/Screening/Immunization	See Page		of	

Routine Eye Exam for Children	See Page		of	
Eye Glasses for Children	See Page		of	
Dental Check-Up for Children	See Page		of	
Rehabilitative Speech Therapy	See Page		of	
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page		of	
Well Baby Visits and Care	See Page		of	
Laboratory Outpatient and Professional Services	See Page		of	
X-rays and Diagnostic Imaging	See Page		of	
Basic Dental Care – Child	See Page		of	
Orthodontia – Child	See Page		of	
Major Dental Care – Child	See Page		of	
Transplant	See Page		of	
Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
Nutritional Counseling	See Page		of	
Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

I, on behalf of _____hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by_____ for review and approval.

_____ _____ _____

Name: Title: Date:

Essential Health Benefits (EHB) Crosswalk and Certification Tool

The benefits included in Indiana's benchmark plan are "essential health benefits" (EHB) and must be included in all policies and plans offered in the individual and small group markets pursuant to 45 CFR §§147.150 and 156.100 et seq. Please submit a complete crosswalk and certification for each policy filed for review. This document should be submitted via SERFF into your supporting documents tab.

Benefit	Location of Benefit in Issuer's Policy			
Primary Care Visit to Treat an Injury or Illness	See Page		of	
Specialist Visit	See Page		of	
Other Practitioner Office Visit (Nurse, Physician Assistant)	See Page		of	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	See Page		of	
Outpatient Surgery Physician/Surgical Services	See Page		of	
Hospice Services	See Page		of	
Private-Duty Nursing	See Page		of	
Urgent Care Centers or Facilities	See Page		of	
Home Health Care Services	See Page		of	
Emergency Room Services	See Page		of	
Emergency Transportation/Ambulance	See Page		of	
Inpatient Hospital Services (e.g., Hospital Stay)	See Page		of	
Inpatient Physician and Surgical Services	See Page		of	
Skilled Nursing Facility	See Page		of	
Prenatal and Postnatal Care	See Page		of	
Delivery and All Inpatient Services for Maternity Care	See Page		of	
Mental/Behavioral Health Outpatient Services	See Page		of	
Mental/Behavioral Health Inpatient Services	See Page		of	
Substance Abuse Disorder Outpatient Services	See Page		of	
Substance Abuse Disorder Inpatient Services	See Page		of	
Generic Drugs	See Page		of	
Preferred Brand Drugs	See Page		of	
Non-Preferred Brand Drugs	See Page		of	
Specialty Drugs	See Page		of	
Outpatient Rehabilitation Services	See Page		of	
Habilitation Services	See Page		of	
Chiropractic Care	See Page		of	
Durable Medical Equipment	See Page		of	
Imaging (CT/PET Scans, MRIs)	See Page		of	
Preventive Care/Screening/Immunization	See Page		of	

Routine Eye Exam for Children	See Page		of	
Eye Glasses for Children	See Page		of	
Dental Check-Up for Children	See Page		of	
Rehabilitative Speech Therapy	See Page		of	
Rehabilitative Occupational and Rehabilitative Physical Therapy	See Page		of	
Well Baby Visits and Care	See Page		of	
Laboratory Outpatient and Professional Services	See Page		of	
X-rays and Diagnostic Imaging	See Page		of	
Basic Dental Care – Child	See Page		of	
Orthodontia – Child	See Page		of	
Major Dental Care – Child	See Page		of	
Transplant	See Page		of	
Accidental Dental	See Page		of	
Dialysis	See Page		of	
Allergy Testing	See Page		of	
Chemotherapy	See Page		of	
Radiation	See Page		of	
Diabetes Education	See Page		of	
Prosthetic Devices	See Page		of	
Infusion Therapy	See Page		of	
Treatment for Temporomandibular Joint Disorders	See Page		of	
Nutritional Counseling	See Page		of	
Reconstructive Surgery	See Page		of	
Clinical Trials	See Page		of	
Diabetes Care Management	See Page		of	
Inherited Metabolic Disorder - PKU	See Page		of	
Off Label Prescription Drugs	See Page		of	
Dental Anesthesia	See Page		of	
Mental Health Other	See Page		of	

I, on behalf of _____hereby certify, based on information and belief formed after reasonable inquiry, that (i) the statements and information contained herein are true, accurate and complete and (ii) all benefits included in Indiana's benchmark plan are included in the policy or policies filed by_____ for review and approval.

_____ _____ _____

Name: Title: Date:

STATEMENT OF VARIABILITY
INDIVIDUAL HMO/HSA and POS – On and OFF Exchange Products
For Contract Forms:
IN_ONHIX_HMHS(1/15)
IN_ONHIX_PS(1/15)
IN_OFFHIX_HMHS(1/15)
IN_OFFHIX_PS(1/15)

General Variable Information

Most numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Definitions may vary to the extent that such definitions may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Website URL addresses (e.g. [www.anthem.com]) are bracketed throughout the Contract for removal if necessary or to update if the web addresses changes.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval.

Please note that the deductible, out of pocket and cost shares value ranges bracketed in the schedule will only be arranged to match our company's individual benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

The following is an explanation of the variables used within this Contract form:

FRONT COVER:

Product Names is bracketed to allow for different names to appear depending on a member's benefit selection. The product names that will populate this area are:

	Catastrophic	HMO	Anthem Catastrophic Pathway X $6600/0%
	Catastrophic	HMO	Anthem Catastrophic Pathway $6600/0%
	Bronze - HSA	HMO	Anthem Bronze Pathway X 0% for HSA
	Bronze	HMO	Anthem Bronze Pathway X 6250/30%
	Bronze	HMO	Anthem Bronze Pathway X 5750/20%

	Bronze	POS	Anthem Bronze Pathway X POS 5000/40%
	Bronze - HSA	HMO	Anthem Bronze Pathway X 20% for HSA
	Bronze	HMO	Anthem Bronze Pathway X 4300/20%
	Silver	HMO	Anthem Silver Pathway X 3500/0%
	Silver	HMO	Anthem Silver Pathway X 3500/0% S04
	Silver	HMO	Anthem Silver Pathway X 3500/0% S05
	Silver	HMO	Anthem Silver Pathway X 3500/0% S06
	Silver - HSA	HMO	Anthem Silver Pathway X 10% for HSA
	Silver - HSA	HMO	Anthem Silver Pathway X 10% for HSA S04
	Silver	HMO	Anthem Silver Pathway X 10% S05
	Silver	HMO	Anthem Silver Pathway X 10% S06
	Silver	HMO	Anthem Silver Pathway X 2500/10%
	Silver	HMO	Anthem Silver Pathway X 2500/10% S04
	Silver	HMO	Anthem Silver Pathway X 250010% S05
	Silver	HMO	Anthem Silver Pathway X 2500/10% S06
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S04
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S05
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S06
	Gold	HMO	Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan
	Bronze	HMO	Anthem Bronze Pathway 5750/20%
	Bronze	HMO	Anthem Bronze Pathway 6000/30%
	Bronze	POS	Anthem Bronze Pathway POS 5000/40%
	Bronze - HSA	HMO	Anthem Bronze Pathway 0% for HSA
	Bronze - HSA	HMO	Anthem Bronze Pathway 20% for HSA
	Silver	HMO	Anthem Silver Pathway 2850/15%
	Silver	HMO	Anthem Silver Pathway 2500/10%
	Silver - HSA	HMO	Anthem Silver Pathway 10% for HSA
	Silver	HMO	Anthem Silver Pathway 1750/20%
	Gold	HMO	Anthem Gold Pathway 1250/10%
	Bronze	HMO	Anthem Bronze Pathway X 0% AI
	Bronze	HMO	Anthem Bronze Pathway X 6250/30% AI
	Bronze	HMO	Anthem Bronze Pathway X 5750/20% AI
	Bronze	POS	Anthem Bronze Pathway X POS 5000/40% AI
	Bronze	HMO	Anthem Bronze Pathway X 20% AI
	Bronze	HMO	Anthem Bronze Pathway X 4300/20% AI

	Silver	HMO	Anthem Silver Pathway X 3500/0% AI
	Silver	HMO	Anthem Silver Pathway X 10% AI
	Silver	HMO	Anthem Silver Pathway X 2500/10% AI
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan AI
	Gold	HMO	Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan AI

Anthem Logo and Company address is bracketed to allow for future change.

SCHEDULE OF BENEFITS:

Deductible amount option ranges are as shown in the schedule, for the different metal option offerings.

HMO/HSA ONLY – HSA specific deductible language is shown within asterisks as optional language that will only pull into HSA products chosen by the member.

Out of Pocket Limit (The most you will pay per calendar year) ranges (individual and family) are as shown in the schedule for the different metal option offerings.

Copayment amount ranges are as shown in the schedule for the different metal option offerings.

Coinsurance/Cost Share options ranges are as shown in schedule for the different metal option offerings.

Visit limits and **Day limit** ranges are as shown in the schedule for the different metal option offerings.

Ambulance – Cost share options ranges are as shown in the schedule.

Doctor visits - Cost share options ranges are as shown in the schedule. 3 different options for this benefit are available and are notated with the asterisk as optional. Only one option will appear in a member's contract based on the product selected.

Durable Medical Equipment - Cost share options ranges are as shown in the schedule.

Emergency room - Cost share options ranges are as shown in the schedule.

Urgent Care Center - Cost share options ranges are as shown in the schedule.

Home Health Care - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Private Duty Nursing - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Hospice Care - Cost share options ranges are as shown in the schedule.

Hospital Services - Cost share options ranges are as shown in the schedule.

Inpatient PM&R - Cost share options ranges are as shown in the schedule. The day limits range is as shown in the schedule for this benefit.

Mental Health/Substance Abuse – Cost share options ranges are as shown in the schedule.

Outpatient Diagnostic tests - Cost share options ranges are as shown in the schedule.

Outpatient Therapy Services - Cost share options ranges are as shown in the schedule. The visit limits range for each of the Therapy Services is as shown in the schedule for these benefits.

Prosthetics - Cost share options ranges are as shown in the schedule.

Skilled Nursing Care - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Surgery - Cost share options ranges are as shown in the schedule.

Transplant HOTT - Cost share options ranges are as shown in the schedule. The dollar limits for the transplant transportation, lodging and unrelated donor search is as shown in the schedule for this benefit.

Prescription Drugs - Cost share options ranges are as shown in the schedule.

Pediatric Dental Services - Cost share options ranges are as shown in the schedule.

Pediatric Vision Services - Cost share options ranges are as shown in the schedule.

Eligible American Indiana statement – This statement will appear in all ON Exchange products as selected.

COVERED SERVICES:

Phone numbers and addresses – bracketed throughout the Covered Services section to allow us to update those if changes are necessary.

CLAIMS PAYMENT:

Deductible Calculation/Out-of-Pocket Limit Calculation –
HMO contract only: Two versions of language are provided within brackets for flexibility. One version for HMO, and one version for HMO/HSA. Only one version of language will appear in a member's contract, depending upon which product they select.

MEMBER GRIEVANCES:

HMO ON HIX contract only –
External Grievance – There are two versions of the External Grievance provision, indicated as optional language within asterisks. The first version is the IN State required provision for the HMO/HSA On Exchange product offering. The second version is the OPM required provision for the MSP On Exchange product offering. Only one version of this language will pull into a member's contract, depending on which product they select. At no time will the language in either version change without first being filed and approved by your department.

Changes in Premium – This provision is bracketed for flexibility, however, it will always appear as shown in a member's contract for ON EXCHANGE. If this value changes, we will file the new value with your department for approval.

Value-Added and Incentive Programs - This provision is bracketed for flexibility. Anthem is currently in discussions with a large corporation regarding an arrangement to offer an Exchange product that could be accompanied by incentives and value-added programs that will be provided by that corporation or its vendors and partners. The bracketed provision will appear as shown in the member's contract, or not appear at all, once a decision regarding this program is finalized.

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700014

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,600.00
Coinsurance (%, Insurer's Cost Share)			99.99%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	100%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	100%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$40.00	☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,935.71
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700024

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,300.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,300.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	100%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	100%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.2%
Metal Tier:	Bronze
	$2,894.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700023

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,250.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	59%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	62%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$20.00	☐	☐		
Preferred Brand Drugs	☐	☐		$50.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.5%
Metal Tier:	Bronze
	$3,062.34
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700020

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	69%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$40.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,037.84
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN076
HIOS Plan ID: 17575IN0760002

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.3%
Metal Tier:	Bronze
	$2,949.40
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700025

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,500.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	73%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.8%
Metal Tier:	Bronze
	$2,976.08
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700021

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,300.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	2

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.6%
Metal Tier:	Bronze
	$3,063.79
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700026

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$3,500.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$4,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.3%
Metal Tier:	Silver
	$3,618.39
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700026_04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$3,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$4,250.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.1%
Metal Tier:	Silver
$3,710.52	
$5,146.76	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700026_05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$800.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$1,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$250.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL)
Actuarial Value:	86.1%
Metal Tier:	Platinum
$4,651.23	
$5,403.01	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700026_06

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$150.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$650.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$100.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$100.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum
$5,412.89	
$5,804.27	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700028

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$3,000.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	77%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	82%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.2%
Metal Tier:	Silver
	$3,512.61
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700028_04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,250.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	77%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	81%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.8%
Metal Tier:	Silver
$3,746.87	
$5,146.76	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700028_05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,150.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$1,150.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	100%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	100%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL)
Actuarial Value:	86.2%
Metal Tier:	Platinum
$4,655.68	
$5,403.01	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700028_06

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$500.00
Coinsurance (%, Insurer's Cost Share)			99.99%
OOP Maximum ($)			$500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	100%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	100%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.3%
Metal Tier:	Platinum
$5,413.84	
$5,804.27	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700027

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$40.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.2%
Metal Tier:	Silver
	$3,615.42
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700027_04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,450.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	79%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	84%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.8%
Metal Tier:	Silver
$3,744.41	
$5,146.76	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700027_05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$750.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$1,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	82%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$25.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL)
Actuarial Value:	86.3%
Metal Tier:	Platinum
$4,663.93	
$5,403.01	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN070
HIOS Plan ID: 17575IN0700027_06

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$200.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	82%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$10.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$30.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.2%
Metal Tier:	Platinum
$5,411.13	
$5,804.27	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930005

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.0%
Metal Tier:	Silver
	$3,602.58
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930005_04

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$4,250.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	69%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	73%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	72.9%
Metal Tier:	Silver
$3,752.82	
$5,146.76	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930005_05

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$1,500.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	71%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$15.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$35.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 87% (150-200% FPL)
Actuarial Value:	86.1%
Metal Tier:	Platinum
$4,653.53	
$5,403.01	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930005_06

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$200.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$10.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$10.00	☐	☐		
Preferred Brand Drugs	☐	☐		$25.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	93.4%
Metal Tier:	Platinum
$5,419.32	
$5,804.27	

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN093
HIOS Plan ID: 17575IN0930006

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,000.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	79%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.5%
Metal Tier:	Gold
	$4,242.46
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770017

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑All	☑All			☑All	☑All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑All	☑All			☑All	☑All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770041

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770042

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770043

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770044

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770045

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770046

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770047

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770048

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770049

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770050

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770051

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770052

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770053

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	3
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770054

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770055

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770056

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	63%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	70%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$25.00	☐	☐		
Preferred Brand Drugs	☐	☐		$55.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.1%
Metal Tier:	Bronze
	$3,043.17
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770018

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770057

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770058

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770059

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770060

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770061

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770062

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770063

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770064

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770065

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770066

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770067

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770068

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770069

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770070

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770071

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770072

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			70.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	58%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$45.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	70%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.0%
Metal Tier:	Bronze
	$2,934.64
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780005

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780006

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780007

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780008

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780009

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780010

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780011

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780012

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780013

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780014

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780015

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$5,000.00			
Coinsurance (%, Insurer's Cost Share)			60.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780016

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780017

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780018

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780019

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780020

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN078
HIOS Plan ID: 17575IN0780021

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			60.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	51%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	51%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$50.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.5%
Metal Tier:	Bronze
	$2,959.47
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770015

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			99.99%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770073

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770074

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770075

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			99.99%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770076

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770077

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770078

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			99.99%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770079

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770080

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770081

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$6,000.00
Coinsurance (%, Insurer's Cost Share)			99.99%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770082

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770083

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770084

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770085

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770086

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770087

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770088

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$6,000.00			
Coinsurance (%, Insurer's Cost Share)			99.99%			
OOP Maximum ($)			$6,450.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☐		$200.00	☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$450.00	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	100%		☐	☐		
Specialist Visit	☑	☑	100%		☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑	100%		☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑	100%		☑	☑		
Rehabilitative Speech Therapy	☑	☑	100%		☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	100%		☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑	100%		☐	☑		
Skilled Nursing Facility	☑	☑	100%		☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	100%		☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑	100%		☐	☐		
Preferred Brand Drugs	☑	☑	100%		☐	☐		
Non-Preferred Brand Drugs	☑	☑	100%		☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑	100%		☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	58.4%
Metal Tier:	Bronze
	$2,906.62
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770016

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770089

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770090

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770091

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770092

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770093

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770094

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770095

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770096

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770097

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770098

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770099

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770100

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770101

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770102

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770103

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770104

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$4,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	74%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.0%
Metal Tier:	Bronze
	$3,035.70
	$4,976.71

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770022

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,850.00			
Coinsurance (%, Insurer's Cost Share)			85.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770105

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770106

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770107

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770108

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770109

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770110

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770111

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770112

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770113

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770114

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☐
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770115

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770116

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770117

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770118

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770119

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770120

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,850.00
Coinsurance (%, Insurer's Cost Share)			85.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	75%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	80%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	68.5%
Metal Tier:	Silver
	$3,522.98
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770019

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770121

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770122

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770123

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770124

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770125

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770126

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770127

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770128

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770129

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770130

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$2,500.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770131

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770132

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770133

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770134

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770135

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770136

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	80%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	86%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.7%
Metal Tier:	Silver
	$3,638.43
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770020

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770137

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770138

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770139

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770140

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770141

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770142

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770143

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770144

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770145

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770146

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770147

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770148

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770149

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770150

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770151

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770152

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$2,500.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$4,000.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	83%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☐	☐		
Preferred Brand Drugs	☑	☑			☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	70.4%
Metal Tier:	Silver
	$3,621.18
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770021

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770153

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770154

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770155

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770156

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770157

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770158

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770159

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770160

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,750.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
OOP Maximum ($)			$6,600.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770161

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770162

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770163

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770164

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770165

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770166

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770167

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
	☑
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770168

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,750.00
Coinsurance (%, Insurer's Cost Share)			80.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	70%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	75%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑		$35.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑
# Copays (1-10):	3

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.0%
Metal Tier:	Silver
	$3,654.74
	$5,146.76

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770023

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770169

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770170

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770171

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770172

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770173

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,950.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770174

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,950.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770175

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,950.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770176

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,950.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770177

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770178

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770179

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770180

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,950.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770181

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770182

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,950.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770183

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,250.00			
Coinsurance (%, Insurer's Cost Share)			90.00%			
OOP Maximum ($)			$3,950.00			
OOP Maximum if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

HIOS Issuer ID: 17575
HIOS Product ID: 17575IN077
HIOS Plan ID: 17575IN0770184

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,250.00
Coinsurance (%, Insurer's Cost Share)			90.00%
OOP Maximum ($)			$3,950.00
OOP Maximum if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑	78%		☑	☐		
All Inpatient Hospital Services (inc. MHSA)	☑	☑	85%		☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☐	☐		
Specialist Visit	☑	☑			☐	☐		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☐	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☐	☐		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☐	☐		
Preventive Care/Screening/Immunization			100%	$0.00				
Laboratory Outpatient and Professional Services	☑	☑			☐	☑		
X-rays and Diagnostic Imaging	☑	☑			☐	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☐	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☐	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☐	☐		$15.00	☐	☐		
Preferred Brand Drugs	☐	☐		$40.00	☐	☐		
Non-Preferred Brand Drugs	☑	☑			☐	☐		
Specialty Drugs (i.e. high-cost)	☑	☑			☐	☑		

Options for Additional Benefit Design Limits:

Do Not Allow Copays to Exceed Service Unit Cost?	☐
Set a Maximum on Specialty Rx Coinsurance Payments?	
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	78.0%
Metal Tier:	Gold
	$4,215.69
	$5,403.01

ACTUARIAL MEMORANDUM

1. General Information

- Company Identifying Information

Company Legal Name:	Anthem Insurance Companies, Inc.
State:	Indiana
HIOS Issuer ID:	17575
NAIC Company Code:	28207
Market:	Individual
Effective Date:	January 1, 2015

- Company Contact Information

Primary Contact Name:	Aaron Smith
Primary Contact Telephone Number:	(317) 287-6452
Primary Contact Email Address:	Aaron.Smith@wellpoint.com

2. Scope and Purpose of the Filing

To the best of Anthem's knowledge and current understanding, this filing complies with the most recent regulations and related guidance. To the extent relevant rules or guidance on the rules are updated or changed, amendments to this filing may be required.

The purpose of this rate filing is to establish rates that are reasonable relative to the benefits provided and to demonstrate compliance with state laws and provisions of the Affordable Care Act (ACA). The rates will be in-force for effective dates on or after January 1, 2015. These rates will apply to plans offered both On-Exchange and Off-Exchange. This rate filing is not intended to be used for other purposes.

Policy Form Number(s):

IN_ONHIX_HMHS(1/15)
IN_OFFHIX_HMHS(1/15)
IN_ONHIX_PS(1/15)
IN_OFFHIX_PS(1/15)

3. Introduction

This filing includes an average rate increase of 9.7%, with range by plan between -3.6% and 19.6%. More details are provided below in Section 5: Proposed Rate Increase, and in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

- Changes from 2014 Filings

Medicaid Spend Down Program - Adjustment due to 1634 Transition. See Section 9: Credibility Manual Rate Development for details.

Tobacco rating factors now vary by age – see Exhibit J: Age and Tobacco Factors.

Area factors have been adjusted to reflect most current experience. Refer to Exhibit K: Area Factors.

This filing includes new exhibits showing the Market Adjusted Index Rate, Plan Adjusted Index Rate, and Consumer Adjusted Premium Rates, as defined in the new memo instructions for 2015 filings. See Exhibit N: Market Adjusted Index Rate Development and Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

4. Description of How the Base Rate Is Determined

The development of the Base Rate is detailed in Exhibit A: Base Rate Development. Further details on how the base rate is developed can be found in Section 9: Credibility Manual Rate Development, Section 12: Risk Adjustment and Reinsurance, Section 13: Non-Benefit Expenses, Profit and Risk, and Section 19: Calibration. A description of the methodology used to determine the base rate is as follows:

- Historical Individual experience is not considered representative of the future market; therefore, the manual rates are developed based on Small Group Grandfathered and Non-Grandfathered experience.
- The experience data is normalized to reflect anticipated changes in age/gender, area/network and benefit plan from the experience period to the projection period based on expected distribution of membership.
- The projected claims cost is calculated by adjusting the normalized claims for the impact of benefit changes, population morbidity, trend factors, other cost of care impacts and other claim adjustments.
- The projection period is January 1, 2015 - December 31, 2015.
- Adjustments for risk adjustment and reinsurance are applied to the projected claims cost.
- Non-benefit expenses, profit, and risk are applied to the projected claims cost to determine the required projection period premium.
- The projection period premium is adjusted by the average rating factors in the projection period to determine the base rate.
- The base rate represents an average benefit plan and area for an age 21 non-tobacco user in Indiana.

Premiums at the member level are determined by multiplying the base rate by the applicable factor for each of the allowable rating criteria: age, tobacco, area and benefit plan. An example of this calculation is shown in Exhibit L: Sample Rate Calculation.

5. Proposed Rate Increase

The average proposed rate increase is 9.7%. Factors that affect the proposed rate increase for all plans include:

- Changes in benefit design
- Anticipated changes in the market-wide morbidity of the covered population in the projection period
- Changing trends in medical costs and utilization and other cost of care impacts
- Anticipated changes in payments from and contributions to the Federal Transitional Reinsurance Program
- Changes in taxes, fees, and other non-benefit expenses

The rate increase is shown in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

Although rates are based on the same single risk pool of experience, proposed rate increases vary by plan from -3.6% to 19.6%. Factors that affect the variation in the proposed rate increase by plan include:

- Changes in benefit design that vary by plan
- Changes in the adjustment factor for Catastrophic eligibility
- Changes in Non-Benefit Expenses that are applied on a PMPM basis
- Changes in the underlying area rating factors

In 2014, the area factors varied by plan based on actuarially justified network cost differences for each geographic rating area. Effective January 1, 2015, a single area factor will apply to all plans in each geographic rating area. To retain the actuarially justified network cost differences for each geographic area and comply with 45 CFR part §147.102, several new plans have been added, each of which is available in a single geographic rating area. New plans have been mapped to comparable 2014 plans for purposes of determining the rate increase. Refer to Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases and Exhibit K: Area Factors for details.

These rate increases by plan are shown in Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

6. Experience Period Premium and Claims

Experience shown in Worksheet 1, Section I of the Unified Rate Review Template is for the Indiana Individual Single Risk Pool Non-Grandfathered Business. This experience is given 0% credibility in the development of manual rates. This is not due to the amount of experience in Worksheet 1, Section I of the Unified Rate Review Template, but rather 0% credibility is applied to this experience because we have instead used combined Grandfathered and Non-Grandfathered Small Group experience in the development of manual rates, as described in Section 10: Credibility of Experience. The manual rates are fully detailed in Section 9: Credibility Manual Rate Development.

Claims experience in Worksheet 1, Section I of the Unified Rate Review Template reflects dates of service from January 1, 2013 through December 31, 2013.

- Paid Through Date

  Claims shown in Worksheet 1, Section I of the Unified Rate Review Template are paid through March 31, 2014.

- Allowed and Incurred Claims Incurred During the Experience Period

  The allowed claims are determined by subtracting non-covered benefits, provider discounts, and coordination of benefits amounts from the billed amount.

  Allowed and incurred claims are completed using the chain ladder method, an industry standard, by using historic paid vs. incurred claims patterns. The method calculates historic completion percentages, representing the percent of claims paid for a particular month after one month of run out, two months, etc., for a forty-eight month view of history. Claim backlog files are reviewed on a monthly basis and are accounted for in the historical completion factor estimates.

- Premiums (net of MLR Rebate) in Experience Period

  The estimated Non-Grandfathered gross earned premium for Indiana Individual is $200,796,023, where earned premium is the pro-rata share of premium owed to Anthem due to subscribers actively purchasing insurance coverage during the experience period.

  The preliminary MLR Rebate estimate is $0, which is consistent with the December 31, 2013 Anthem general ledger estimate allocated to the Non-Grandfathered portion of Individual. Note that this is an estimate and will not be final until June 1, 2014.

7. Benefit Categories

The methodology used to determine benefit categories in Worksheet 1, Section II of the Unified Rate Review Template is as follows:

- Inpatient Hospital: Includes non-capitated facility services for medical, surgical, maternity, mental health and substance abuse, skilled nursing, and other services provided in an inpatient facility setting and billed by the facility.
- Outpatient Hospital: Includes non-capitated facility services for surgery, emergency room, lab, radiology, therapy, observation and other services provided in an outpatient facility setting and billed by the facility.
- Professional: Includes non-capitated primary care, specialist, therapy, the professional component of laboratory and radiology, and other professional services, other than hospital-based professionals whose payments are included in facility fees.
- Other Medical: Includes non-capitated ambulance, home health care, DME, prosthetics, supplies, vision exams, dental services and other services.
- Capitation: Includes all services provided under one or more capitated arrangements.
- Prescription Drug: Includes drugs dispensed by a pharmacy and rebates received from drug manufacturers.

8. Projection Factors

As previously indicated, the credibility level assigned to the experience in Worksheet 1, Section III of the Unified Rate Review Template is 0%. Consequently, factors to project experience claims are not provided as they are not applicable. However, the factors used to develop the manual rates are fully detailed in Section 9: Credibility Manual Rate Development.

• Changes in the Morbidity of the Population Insured

n/a - see Credibility Manual Rate Development

• Changes in Benefits

n/a - see Credibility Manual Rate Development

• Changes in Demographics

n/a - see Credibility Manual Rate Development

• Other Adjustments

n/a - see Credibility Manual Rate Development

• Trend Factors (cost/utilization)

n/a - see Credibility Manual Rate Development

9. Credibility Manual Rate Development

Experience developed and projected herein is Anthem's Small Group Business based on plan liability amounts. The rate development is shown in Exhibit A: Base Rate Development.

• Source and Appropriateness of Experience Data Used

As mentioned in Section 4: Description of How the Base Rate Is Determined and Section 6: Experience Period Premium and Claims, historical Individual experience is not considered representative of the 2015 market environment due to ACA requirements of guarantee issue, EHB, minimum actuarial value constraints, and other mandate changes. Historical Small Group experience is more reflective of the 2015 population since Small Group business is already guarantee issue with no medical underwriting, and benefit designs are closer to the 2015 ACA requirements. Therefore, Anthem is using all Grandfathered and Non-Grandfathered Small Group experience to develop manual rates.

The source data underlying the development of the manual rate consists of claims for all Grandfathered and Non-Grandfathered Small Group business, incurred during the period January 1, 2013 – December 31, 2013 and paid through March 31, 2014. Completion factors are then calculated to reflect additional months of runout after March 31, 2014. Anthem expects a portion of the Grandfathered policyholders to migrate to ACA-compliant policies prior to and during the projection period.

In developing rates effective January 1, 2015, only limited 2014 experience is available. This experience is not deemed credible for purposes of rate development.

Experience is adjusted as follows:

- Claims incurred for members who live out-of-state were excluded; however, claims incurred by in-state members traveling out-of-state were included.

For more detail, see Exhibit B: Claims Experience for Manual Rate Development.

• Adjustments Made to the Data

The development of the projected claims is summarized in Exhibit A: Base Rate Development, items (1) - (10), and described in detail below.

The projected claims cost is calculated by multiplying the normalized claims cost by the impact of benefit changes, anticipated changes in population morbidity, and cost of care impacts. The adjustments are described below, and the factors are presented in Exhibit D: Projection Period Adjustments. In addition, the source data is normalized for seasonality and changes in the provider contracts.

Changes in Demographics (Normalization)

The source data was normalized to reflect anticipated changes in age/gender, area, network, and benefit plan from the experience period to the projection period. The purpose of these factors is to adjust current experience to be reflective of expected claim experience in the projection period. See Section 23: Membership Projections for additional information on membership movement. The normalization factors and their aggregate impact on the underlying experience data are detailed in Exhibit C: Normalization Factors.

- Age/Gender: The assumed claims cost is applied by age and gender to the experience period distribution and the projection period distribution.
- Area/Network: The area claims factors are developed based on an analysis of Small Group and Individual allowed claims by network, mapped to the prescribed 2015 rating areas using 5-digit zip code.
- Benefit Plan: The experience period claims are normalized to an average 2015 plan using benefit relativities. The benefit relativities include the value of cost shares and anticipated changes in utilization due to the difference in average cost share requirements.

Changes in Benefits

Benefit changes include the following:

- Preventive Rx (over the counter): The claims are adjusted for 100% coverage of benefits for specific over the counter drugs obtained with a prescription from a physician.
- Rx Adjustments: The claims are adjusted for differences in the Rx formulary and the impact of moving drugs into different tiers in the projection period relative to what is reflected in the base experience data.

Changes in the Morbidity of the Population Insured

Morbidity changes include the following (for Morbidity factor, see Exhibit D: Projection Period Adjustments):

- Higher morbidity expected from individual-level purchasing decisions in 2015: Anthem assumes that the morbidity of the smallest groups, sizes 2 – 5 members, relative to the total small group population are a reasonable approximation for the health status of the individual market. Relative morbidity by group size is based on health status determined from internal risk score data.
- Higher morbidity of the uninsured compared to the insured population: This adjustment is based on a CDC study on the health status and life styles of both currently insured and uninsured populations. This adjustment also considers the expected number of previously uninsured individuals expected to move into the Individual market in 2015.

- Pent-up demand: As previously uninsured individuals obtain insurance in 2015, Anthem expects them to have some pent-up demand for health care services. An adjustment is needed to account for this additional utilization of health care services in year one. Previously uninsured individuals are assumed to utilize more health care services due to pent-up demand. Currently insured members are assumed to have no pent-up demand for health care services in year one.

- Morbidity of Non-Grandfathered compared to Grandfathered members: The base period experience includes Grandfathered and Non-Grandfathered members. The experience is adjusted to account for the different morbidity between Grandfathered and Non-Grandfathered members to derive a Non-Grandfathered only rate.

Our goal is to price to the average risk of the 2015 ACA market. Since Anthem-specific 2013 experience was used as a starting point, we adjusted this experience to be more consistent with the overall 2013 market in Indiana. Wakely Consulting collected demographic and risk information from carriers, and calculated Anthem's relative risk to the market for 2013. We have adjusted our starting experience using the results of that survey.

Trend Factors

- The annual pricing trend used in the development of the rates is 11.3%. The trend is developed by normalizing historical benefit expense for changes in the underlying population and known cost drivers, and the result is projected forward. The trend includes a volatility provision in accordance with Actuarial Standards of Practice. The claims are trended 24 months from the midpoint of the experience period, which is July 1, 2013, to the midpoint of the projection period, which is July 1, 2015.

- Projected trends include the estimated cost during 2014 and 2015 of the pharmaceutical Sovaldi and other high-cost drugs for treating Hepatitis C. These cost estimates were based on claims experience for Anthem's Individual business, together with CDC recommendations and Industry and Enterprise data.

Other Cost of Care Impacts

- Induced Demand Due to Cost Share Reductions: Individuals below 200% Federal Poverty Level who enroll in silver plans On-Exchange will be eligible for cost share reductions. As a result, the base period experience is adjusted to account for the higher anticipated utilization levels.

- Medicaid Spend Down: An adjustment is needed to account for the planned 1634 Transition on June 1, 2014. As a result of this transition, the State will be ceasing operations of the Spend Down Program and approximately 6,800 plan participants will move into the commercial market. The transitioning Spend Down participants have average claims on an annual basis of approximately $21,000 per member per year at current Medicaid reimbursement levels.

- Pervasive Development Disorder Mandate: A Cost of Care adjustment is needed to account for the fact that there are not significant costs related to Pervasive Development Disorders (PDD) in the Small Group base period experience. In the Individual and Small Group markets today, insurers cannot deny or restrict coverage because an individual is diagnosed with PDD. This mandate results in adverse selection, which uniquely impacts the Individual market. Recently, utilization of an expensive type of therapy called applied behavior analysis (ABA) used to treat individuals with PDD has increased significantly in the market. Anthem is required by the state mandate to cover these expensive medical services. In 2013, Anthem paid approximately $13 million in medical costs for ABA therapy. The costs for currently insured individuals receiving ABA therapy have been projected into the projection period to determine this adjustment.

- Utilization or cost-per-service change: anticipated changes are reflected in the morbidity changes and trend.
- Change in Medical Management: medical management savings not already included in the claims experience and trend.
- Change in Provider Contracts: anticipated changes in provider contracts are reflected in the benefit plan factors and the region rating factors.

Other Claim Adjustments

The adjustments described below are presented in Exhibit E: Other Claim Adjustments.

- Rx Rebates: The projected claims cost is adjusted to reflect anticipated Rx rebates. These projections take into account the most up-to-date information regarding anticipated rebate contracts, drug prices, anticipated price inflation, and upcoming patent expirations.

- The cost of adding benefits for pediatric dental and vision are included.

• Capitation Payments

The underlying data includes capitation payments, which are combined with the base medical and pharmacy claims and projected at the same rate. No further adjustment is made to the capitation.

10. Credibility of Experience

The underlying experience data does not reasonably reflect Individual claims experience under the future market conditions. Anthem believes that Small Group experience is more representative of the future projection period. Actuarial judgment has been exercised to determine that rates will be developed giving full credibility to the data underlying the manual rate in Section 9: Credibility Manual Rate Development.

• Resulting Credibility Level Assigned to Base Period Experience

The credibility level assigned to the experience in Worksheet 1, Section III of the Unified Rate Review Template is 0%.

11. Paid to Allowed Ratio

The 'Paid to Allowed Average Factor in Projection Period' shown in Worksheet 1, Section III of the Unified Rate Review Template is developed by membership-weighted essential health benefit paid claims divided by membership-weighted essential health benefit allowed claims of each plan. The projected membership by plan is shown in Worksheet 2, Section II.

12. Risk Adjustment and Reinsurance

- Projected Risk Adjustment

The Risk Adjustment program transfers funds from lower risk plans to higher risk plans in the Non-Grandfathered Individual and Small Group market. The HHS operated Risk Adjustment program is supported by a user fee, as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

Anthem is assuming the risk for the plans in this filing are no better or worse than other plans in the market, resulting in no estimated risk transfer value as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

- Projected ACA Reinsurance Recoveries Net of Reinsurance Premium

The transitional reinsurance risk mitigation program collects funds from all insurance issuers and TPAs and redistributes them to high cost claimants in the Non-Grandfathered Individual market. The reinsurance contribution is equal to the national per capita reinsurance contribution rate as shown in Exhibit F: Risk Adjustment and Reinsurance - Contributions and Payments.

The reinsurance payment is developed using projected paid claims, claim probability distribution, and reinsurance payment guidelines. The claim probability distribution observes claims between $70K and $250K using a claim probability distribution that reflects the anticipated claim cost distribution of the 2015 Individual market. The coinsurance rate is 50%. Expected paid claims are calculated for an assumed average On-Exchange plan design. Reinsurance payments are allocated proportionally by plan premiums to all plans in the risk pool.

13. Non-Benefit Expenses, Profit and Risk

Non-Benefit expenses are detailed in Exhibit G: Non-Benefit Expenses and Profit & Risk.

- Administrative Expense

Administrative Expense contains both acquisition costs associated with the production of new business through non-broker distribution channels (direct, telesales, etc) as well as maintenance costs associated with ongoing costs for the administration of the business. Acquisition costs are projected using historical cost per member sold amounts applied to future sales estimates. Maintenance costs are assumed to be flat on a per member basis with savings from fixed cost leverage and the elimination of underwriting offset by new expenses for risk management, regulatory compliance and premium reconciliation and balancing.

- Quality Improvement Expense

The quality improvement expense represents Anthem's dedication to providing the highest standard of customer care and consistently seeking to improve health care quality, outcomes and value in a cost efficient manner.

The QI Expense assumptions are based on historical amounts related to the following initiatives: Improve Health Outcomes, Activities to Prevent Hospital Readmissions, Improve Patient Safety and Reduce Medical Errors, Wellness and Health Promotion Activities, HIT Expenses for Health Care Quality Improvements, Other Cost Containment and ICD-10.

- Selling Expense

Selling Expense represents broker commissions and bonuses associated with the broker distribution channel using historical and projected commission levels. Commissions will be paid both On-Exchange and Off-Exchange.

- Taxes and Fees

  - Patient-Centered Outcomes Research Institute (PCORI) Fee: The PCORI fee is a federally-mandated fee designed to help fund the Patient-Centered Outcomes Research Trust Fund. For plan years ending before October 1, 2014, the fee is $2 per member per year. Thereafter, for every plan year ending before October 1, 2019, the fee will increase by the percentage increase in National Healthcare Expenditures.
  - ACA Insurer Fee: The health insurance industry will be assessed a permanent fee, based on market share of net premium, which is not tax deductible. The tax impact of non-deductibility is captured in this fee.
  - Exchange Fee: The Exchange User Fee applies to Exchange business only, but the cost is spread across all Individual plans. A blended fee/percentage is determined based on an assumed 74% of members that will purchase products On-Exchange. The resulting fee/percentage is applied evenly to all plans in the risk pool, both On and Off Exchange.
  - Premium taxes, federal income taxes and state income taxes are also included in the retention items.

- Profit

Profit is reflected on a post-tax basis as a percent that does not vary by product or plan. The profit percentage does not include any assumed risk corridor payments or receipts.

14. Projected Loss Ratio

- Projected Federal MLR

The projected Federal MLR for the products in this filing is estimated in Exhibit M: Federal MLR Estimated Calculation. Please note that this calculation is purely an estimate and not meant to be a true measure for Federal or State MLR rebate purposes. The products in this filing represent only a subset of Anthem's Individual business. The MLR for Anthem's entire book of Individual business will be compared to the minimum Federal benchmark for purposes of determining regulation-related premium refunds. Also note that the projected Federal MLR presented here does not capture all adjustments, including but not limited to: three-year averaging, credibility, dual option, and deductible. Anthem's projected MLR is expected to meet or exceed the minimum MLR standards at the market level after including all adjustments.

15. Single Risk Pool

As described above in Section 4: Description of How the Base Rate Is Determined, the Anthem Index Rate for Individual business in Indiana is based on total combined claims costs for providing essential health benefits within the single risk pool of non-grandfathered Individual plans in Indiana. The Index Rate is adjusted on a market-wide basis for the state based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs and Exchange user fees. The premium rates for all Anthem non-grandfathered plans in the Individual market use the applicable market-wide adjusted index rate, subject only to the permitted plan-level adjustments. This demonstrates that the Single Risk Pool for Anthem Individual business is established according to the requirements in 45 CFR part 156, §156.80(d).

16. Index Rate

- Experience Period Index Rate

The index rate represents the average allowed claims PMPM of essential health benefits for Anthem's Individual Non-Grandfathered Business. The experience period index rate shown in Worksheet 1, Section I (cell G17) of the Unified Rate Review Template is $270.00 and is the same as the experience period allowed claims (cell G16 in the same location). A comparison to the benchmark was performed, and only essential health benefits were covered during the experience period.

- Projection Period Index Rate

The index rate represents the average allowed claims PMPM of essential health benefits for Anthem's Individual Non-Grandfathered Business. The projection period index rate was developed as shown in Exhibit N: Market Adjusted Index Rate Development by adjusting the projected incurred claims PMPM described in Section 9: Credibility Manual Rate Development of this memorandum. No benefits in excess of the essential health benefits are included in the projection period allowed claims (cell T30 of Worksheet 1, Section II of the Unified Rate Review Template) or Exhibit N: Market Adjusted Index Rate Development's projection period index rate (also shown in cell V44 of Worksheet 1, Section III of the Unified Rate Review Template).

17. Market Adjusted Index Rate

The Market Adjusted Index rate is calculated as the Index Rate adjusted for all allowable market wide modifiers defined in the market rating rules. This development is presented in Exhibit N: Market Adjusted Index Rate Development.

18. Plan Adjusted Index Rate

The Plan Adjusted Index Rate is calculated as the Market Adjusted Index Rate adjusted for all allowable plan level modifiers defined in the market rating rules. This development is presented in Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

- Plan Level Modifiers

  - Cost Sharing Adjustments: This is a multiplicative factor that adjusts for the projected paid/allowed ratio of each plan, based on the AV metal value with an adjustment for utilization differences due to differences in cost sharing. This also includes an adjustment for the average tobacco factor shown in Exhibit H: Calibration .
  - Provider Network Adjustments: This is a multiplicative factor that adjusts for differences in projected claims cost due to different network discounts.
  - Adjustments for Benefits in Addition to EHBs: This multiplicative factor adjusts for additional benefits that are not EHBs.
  - Adjustments for administrative cost: This is an additive adjustment that includes all the Selling Expense, Administration and Other Retention Items shown in Exhibit G: Non-Benefit Expenses and Profit & Risk, with the exception of the Exchange User Fee.

19. Calibration

The required premium in the projection period is calibrated by the average rating calibration factors (Age, Area, and Plan Factor), which are used to develop the Consumer Adjusted Premium Rates. The average rating factors are shown in Exhibit H: Calibration, Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates, and applied in line item 14 of Exhibit A: Base Rate Development.

- Benefit Plan Factors

The benefit plan rating factors are applied to the projection period distribution.

Benefit plan factors also consider the following adjustments, as applicable.

- Induced Utilization Adjustment: The induced utilization adjustment accounts for member behavior variations depending on the richness of the benefit design.
- Pediatric Dental and Vision Benefits: For plans excluding the pediatric dental benefit and pediatric vision benefit, the benefit plan factor reflects reduced benefits.
- Non-EHBs: For plans including benefits in addition to EHBs, the benefit plan factor reflects enhanced benefits.
- Catastrophic Factor: This adjustment assumes a healthier than average population will select the catastrophic plan. The catastrophic adjustment factor is normalized to 1.0 across all plans in the Single Risk Pool.
- Provider Network: This factor accounts for differences in contracted rates and network structure.

Refer to Exhibit I: Non-Grandfathered Benefit Plan Factors and Rate Increases.

• Age Factors

- Refer to Exhibit J: Age and Tobacco Factors.

• Area Factors

In 2014, the area factors varied by plan based on actuarially justified network cost differences for each geographic rating area. Effective January 1, 2015, a single area factor will apply to all plans in each geographic rating area.

Area factors have been adjusted to reflect the most current experience. Refer to Exhibit K: Area Factors.

20. Consumer Adjusted Premium Rate

The Consumer Adjusted Premium Rate is calculated as the Plan Adjusted Index Rate calibrated as described in the previous section. This development is presented in Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates. The calibration is shown in Exhibit H: Calibration.

21. Actuarial Value Metal Values

The Actuarial Value (AV) Metal Values included in Worksheet 2 of the Unified Rate Review Template are based on the AV Calculator. To the extent a component of the benefit design was not accommodated by an available input within the AV Calculator, the benefit characteristic was adjusted to be actuarially equivalent to an available input within the AV Calculator for purposes of utilizing the AV Calculator as the basis for the AV Metal Values. Benefits for Plans that are not compatible with the parameters of the AV Calculator have been separately identified and documented in the Unique Plan Design Supporting Documentation and Justification that supports the Plan & Benefits Template.

22. Actuarial Value Pricing Values

The AV Pricing Values for each Product ID are in Worksheet 2, Section I of the Unified Rate Review Template. The fixed reference plan selected as the basis for the AV Pricing Value calculations is '17575IN0770020'. Consistent with final Market rules, utilization adjustments are made to account for member behavior variations based upon cost-share variations of the benefit design and not the health status of the member. The average allowable modifiers to the Index Rate can be found in Exhibit O: Plan Adjusted Index Rate and Consumer Adjusted Premium Rates.

23. Membership Projections

Membership projections in Worksheet 2 of the Unified Rate Review Template are developed using a population movement model plus adjustments for sales expectations. This model projects the membership in the projection period by taking into account:

- Uninsured to Individual as a result of guaranteed issue, subsidized coverage, and individual mandate
- Small Group to Individual as a result of guaranteed issue and rate disruptions due to the transition to Modified Community Rating
- High Risk Pools to Individual as a result of guaranteed issue
- Individual and Uninsured to Medicaid

The plan distribution is based on assumed metal tier and network distributions. Some 2014 preliminary enrollment information has been considered in projecting membership distributions.

The projected morbidity changes shown in Exhibit D: Projection Period Adjustments include expected morbidity changes due to population movement.

Cost share reduction subsidies will be available on silver level plans. Anthem ran projections to estimate enrollment by income level in each of the plans. Projected enrollment by plan and subsidy level can be found in Exhibit P: Membership Projections for Cost-Sharing Reductions.

24. Warning Alerts

There are no warning alerts indicated on Worksheet 2 of the Unified Rate Review Template.

25. Plan Type

Plan types in Worksheet 2, Section I of the URRT adequately describe Anthem's plans.

26. Reliance

In support of this rate development, various data and analyses were provided by other members of Anthem's internal actuarial staff, including data and analysis related to cost of care, valuation, and pricing. I have reviewed these data and analyses for reasonableness and consistency. I have also relied on Brian Renshaw, FSA, MAAA to provide the actuarial certification for the Unique Plan Design Supporting Documentation and Justification for plans included in this filing.

27. Actuarial Certification

I, Nicole Styka, FSA, MAAA, am an actuary for Anthem. I am a member of the American Academy of Actuaries and a Fellow of the Society of Actuaries. I meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. I hereby certify that the following statements are true to the best of my knowledge with regards to this filing:

(1) The projected Index Rate is:

- In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1)),
- Developed in compliance with the applicable Actuarial Standards of Practice
- Reasonable in relation to the benefits provided and the population anticipated to be covered
- Neither excessive nor deficient.

(2) The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan level rates.

(3) The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV is calculated in accordance with actuarial standards of practice.

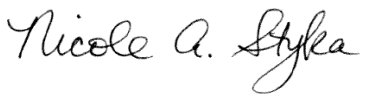
(4) The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans.

(5) On/Off Exchange Attestation: A single base premium rate has been developed for both on and off exchange plans using the same underlying experience data. The premium rates for on and off exchange plans vary only due to differences in the provider network and benefit design.

(6) QHP Off Exchange Premium Tax Credit (PTC) Attestation: To notify consumers that coverage purchased outside of the Exchange is not eligible for premium tax credit assistance, we will include in marketing materials language substantially as follows:

The Patient Protection and Affordability Care Act (PPACA) includes provisions to lower premiums for people with low to modest incomes through a tax credit. The tax credit is only available for qualifying individuals who purchase their individual coverage through the Exchange. Please note that this plan is not eligible for financial assistance through the premium tax credit provision because it is not purchased through the Exchange.

The Part I Unified Rate Review Template does not demonstrate the process used by the issuer to develop the rates. Rather it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of Qualified Health Plans for Federally-Facilitated Exchanges, and for certification that the Index Rate is developed in accordance with Federal regulation, used consistently, and only adjusted by the allowable modifiers. However, this Actuarial Memo does accurately describe the process used by the issuer to develop the rates.



Nicole Styka, FSA, MAAA
Regional Vice President and Actuary III

May 9, 2014
Date

Exhibit A - Base Rate Development

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

			Paid Claims	
1)	Experience Period Cost PMPM	$	275.71	Exhibit B
2)	x Normalization Factor		1.0117	Exhibit C
3)	= Normalized Claims	$	278.94	= (1) x (2)
4)	x Benefit Changes		0.9592	Exhibit D
5)	x Morbidity Changes		1.1426	Exhibit D
6)	x Trend Factor		1.2387	Exhibit D
7)	x Other Cost of Care Impacts		1.1483	Exhibit D
8)	= Projected Claim Cost	$	434.85	= (3) x (4) x (5) x (6) x (7)
9)	+ Other Claim Adjustments	$	(4.67)	Exhibit E
10)	= Claims Projected to Projection Period	$	430.18	= (8) + (9)
11)	+ Risk Adjustment and Reinsurance - Contributions and Payments	$	(30.55)	Exhibit F
12)	+ Non-Benefit Expenses and Profit & Risk {1}	$	94.92	Exhibit G
13)	= Required Premium in Projection Period	$	494.55	= (10) + (11) + (12)
14)	÷ Calibration Factor		1.7079	Exhibit H
15)	÷ Tobacco Average Rating Factor		1.0336	Exhibit H
16)	= Required Base Rate (Average Plan Level - Age 21 - Non-Tobacco)	$	280.15	= (13) ÷ (14) ÷ (15)
17)	Projected Loss Ratio (Conventional Basis)		80.8%	= [(10) + (11)] ÷ (13)

NOTES:

{1} Equivalent to PMPM expenses on Exhibit G + % of premium expenses on Exhibit G applied to Required Premium (Row 13 above).

Exhibit B - Claims Experience for Manual Rate Development

Anthem Insurance Companies, Inc.
Individual

Incurred January 1, 2013 through December 31, 2013
Paid through March 31, 2014

PAID CLAIMS:									
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM
$ 300,084,409	$ 68,767,025	$ 33,448,874	$ 2,924,264	$ 333,533,283	$ 71,691,289	$ -	$ 405,224,572	1,469,749	**$ 275.71**

ALLOWED CLAIMS:									
Incurred and Paid Claims:		IBNR:		Fully Incurred Claims:			Total	Member	Total
Medical	Drug	Medical	Drug	Medical	Drug	Capitation	Benefit Expense	Months	PMPM
$ 405,828,921	$ 96,626,885	$ 43,446,118	$ 3,879,731	$ 449,275,039	$ 100,506,616	$ -	$ 549,781,655	1,469,749	**$ 374.06**

Exhibit C - Normalization Factors

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

	Average Claim Factors		
	Experience Period Population	Future Population	Normalization Factor
Age/Gender	0.9660	1.2508	1.2948
Area/Network	1.0064	0.9064	0.9006
Benefit Plan	0.7495	0.6502	0.8676
Total			**1.0117**

Exhibit D - Projection Period Adjustments

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Impact of Changes Between Experience Period and Projection Period:		
		Adjustment Factor
Benefit changes		
	Preventive Rx (over the counter)	1.0001
	Rx Adjustments {1}	0.9591
	Total Benefit Changes	0.9592
Morbidity changes		
	Total Morbidity Changes	1.1426
Cost of care impacts		
	Annual Medical/Rx Trend Rate	11.30%
	# Months of Projection	24
	Trend Factor	1.2387
	Medicaid Spend Down	1.0880
	PDD Adjustment	1.0280
	Induced Demand for CSR	1.0267
	Total other Impacts	1.1484

NOTES:

{1} Includes Rx formulary and impacts for moving drugs into different tiers

Exhibit E - Other Claim Adjustments

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Adjustments to projection period claims to reflect covered benefits not included in experience period data:	
	PMPM
Rx Rebates	($5.97)
Pediatric Dental	$0.58
Pediatric Vision	$0.72
Total	($4.67)

NOTES:

Adjustments above reflect ONLY additional costs beyond those already captured in line Item 8 of Exhibit A.

Exhibit F - Risk Adjustment and Reinsurance - Contributions and Payments

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Risk Adjustment:

PMPM	User Fee	Net Transfer
Federal Program	$0.08	$0.00

Note:

It is assumed the risk for the plans included in this rate filing is no better/worse than any other plans within this market.

Reinsurance:

PMPM	Contributions Made	Expected Receipts	
Federal Program	$3.67	($34.30)	*Small Group Plans contribute funds but only Individual Plans are eligible to receive payments*

Source:

HHS estimates a national per capita contribution rate of $3.67 per month ($44 per year) in benefit year 2015 (per Payment Parameter Rule).

Grand Total of All Risk Mitigation Programs	($30.55)

Exhibit G - Non-Benefit Expenses and Profit & Risk

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

	Expenses Applied As a PMPM Cost	Expenses Applied as a % of Premium	Expressed as a PMPM {1}
Administrative Expenses			
Administrative Costs	$27.55		
Quality Improvement Expense	$3.98		
Selling Expense	$5.99		
Selling Expense		0.00%	
Specialty Expenses	$0.20		
Total Administrative Expenses	**$37.72**	**0.00%**	$37.72
Taxes and Fees			
PCORI Fee	$0.18		
ACA Insurer Fee		3.79%	
Exchange Fee		2.61%	
Premium Tax		0.00%	
MLR-Deductible Federal/State Income Taxes {2}		1.94%	
Total Taxes and Fees	**$0.18**	**8.34%**	$41.43
Profit and Risk {3}		3.19%	$15.78
Total Non-Benefit Expenses, Profit, and Risk	**$37.90**	**11.53%**	**$94.92**

NOTES:

{1} The sum of the rounded percentages shown may not equal the total at the bottom of the table due to rounding.

{2} Includes only those income taxes which are deductible from the MLR denominator; in particular, Federal income taxes on investment income are excluded.

{3} Profit shown here is post-tax profit, net of those federal and state income taxes which are deductible from the MLR denominator.

Exhibit H - Calibration

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Average 2015 rating factors for 2015 population:	
	Average Rating Factor
Tobacco	1.0336
	Calibration Factors
Age	1.7079
Area	1.0000
Benefit Plan	1.0000
Total Calibration Factor	1.7079
Total Average Rating Factor	1.7653

NOTES:

See Line Item 14 on Exhibit A.

The base rate is developed by dividing the required premium in the projection period by the total average rating factor shown above.

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Catastrophic DirectAccess	17575IN0700014	On/Off	Catastrophic	0.6429	IN IND:-:Pathway X HMO/POS	All	17575IN0700014	6.13%
Anthem Bronze DirectAccess w/HSA caar	17575IN0700024	On/Off	Bronze	0.7962	IN IND:-:Pathway X HMO/POS	All	17575IN0700004	11.27%
Anthem Bronze DirectAccess caae	17575IN0700023	On/Off	Bronze	0.8510	IN IND:-:Pathway X HMO/POS	All	17575IN0700003	9.88%
Anthem Bronze DirectAccess caaa	17575IN0700020	On/Off	Bronze	0.8601	IN IND:-:Pathway X HMO/POS	All	17575IN0700001	9.79%
Anthem Bronze DirectAccess w/HSA cabm	17575IN0700025	On/Off	Bronze	0.7979	IN IND:-:Pathway X HMO/POS	All	17575IN0700005	10.41%
Anthem Bronze DirectAccess cabr	17575IN0700021	On/Off	Bronze	0.8609	IN IND:-:Pathway X HMO/POS	All	17575IN0700002	16.63%
Anthem Silver DirectAccess cbaa	17575IN0700026	On/Off	Silver	1.0708	IN IND:-:Pathway X HMO/POS	All	17575IN0700008	11.38%
Anthem Silver DirectAccess w/HSA cbbg	17575IN0700028	On/Off	Silver	0.9872	IN IND:-:Pathway X HMO/POS	All	17575IN0700011	11.43%
Anthem Silver DirectAccess cbds	17575IN0700027	On/Off	Silver	1.0655	IN IND:-:Pathway X HMO/POS	All	17575IN0700010	15.18%
Anthem Bronze DirectAccess caca	17575IN0760002	On/Off	Bronze	0.8091	IN IND:-:Pathway X HMO/POS	All	17575IN0760001	13.95%
Anthem Bronze Pathway 5750/20%	17575IN0770017	Off	Bronze	0.9367	IN IND:-:Pathway HMO/POS	1	17575IN0770003	10.41%
Anthem Bronze Pathway 5750/20%	17575IN0770041	Off	Bronze	0.9515	IN IND:-:Pathway HMO/POS	2	17575IN0770003	11.46%
Anthem Bronze Pathway 5750/20%	17575IN0770042	Off	Bronze	0.9558	IN IND:-:Pathway HMO/POS	3	17575IN0770003	5.71%
Anthem Bronze Pathway 5750/20%	17575IN0770043	Off	Bronze	0.9566	IN IND:-:Pathway HMO/POS	4	17575IN0770003	14.26%
Anthem Bronze Pathway 5750/20%	17575IN0770044	Off	Bronze	0.9353	IN IND:-:Pathway HMO/POS	5	17575IN0770003	15.21%
Anthem Bronze Pathway 5750/20%	17575IN0770045	Off	Bronze	0.9391	IN IND:-:Pathway HMO/POS	6	17575IN0770003	11.76%
Anthem Bronze Pathway 5750/20%	17575IN0770046	Off	Bronze	0.9360	IN IND:-:Pathway HMO/POS	7	17575IN0770003	8.74%
Anthem Bronze Pathway 5750/20%	17575IN0770047	Off	Bronze	0.9360	IN IND:-:Pathway HMO/POS	8	17575IN0770003	3.59%
Anthem Bronze Pathway 5750/20%	17575IN0770048	Off	Bronze	0.9361	IN IND:-:Pathway HMO/POS	9	17575IN0770003	9.53%
Anthem Bronze Pathway 5750/20%	17575IN0770049	Off	Bronze	0.9340	IN IND:-:Pathway HMO/POS	10	17575IN0770003	5.92%
Anthem Bronze Pathway 5750/20%	17575IN0770050	Off	Bronze	0.9337	IN IND:-:Pathway HMO/POS	11	17575IN0770003	7.20%
Anthem Bronze Pathway 5750/20%	17575IN0770051	Off	Bronze	0.9287	IN IND:-:Pathway HMO/POS	12	17575IN0770003	16.01%
Anthem Bronze Pathway 5750/20%	17575IN0770052	Off	Bronze	0.9220	IN IND:-:Pathway HMO/POS	13	17575IN0770003	7.90%
Anthem Bronze Pathway 5750/20%	17575IN0770053	Off	Bronze	0.9006	IN IND:-:Pathway HMO/POS	14	17575IN0770003	1.73%
Anthem Bronze Pathway 5750/20%	17575IN0770054	Off	Bronze	0.9250	IN IND:-:Pathway HMO/POS	15	17575IN0770003	2.83%
Anthem Bronze Pathway 5750/20%	17575IN0770055	Off	Bronze	0.8715	IN IND:-:Pathway HMO/POS	16	17575IN0770003	4.30%
Anthem Bronze Pathway 5750/20%	17575IN0770056	Off	Bronze	0.9333	IN IND:-:Pathway HMO/POS	17	17575IN0770003	8.89%
Anthem Bronze Pathway 6000/30%	17575IN0770018	Off	Bronze	0.8815	IN IND:-:Pathway HMO/POS	1	17575IN0770005	4.67%
Anthem Bronze Pathway 6000/30%	17575IN0770057	Off	Bronze	0.8955	IN IND:-:Pathway HMO/POS	2	17575IN0770005	5.65%
Anthem Bronze Pathway 6000/30%	17575IN0770058	Off	Bronze	0.8995	IN IND:-:Pathway HMO/POS	3	17575IN0770005	0.21%
Anthem Bronze Pathway 6000/30%	17575IN0770059	Off	Bronze	0.9003	IN IND:-:Pathway HMO/POS	4	17575IN0770005	8.31%
Anthem Bronze Pathway 6000/30%	17575IN0770060	Off	Bronze	0.8803	IN IND:-:Pathway HMO/POS	5	17575IN0770005	9.21%
Anthem Bronze Pathway 6000/30%	17575IN0770061	Off	Bronze	0.8839	IN IND:-:Pathway HMO/POS	6	17575IN0770005	5.94%
Anthem Bronze Pathway 6000/30%	17575IN0770062	Off	Bronze	0.8809	IN IND:-:Pathway HMO/POS	7	17575IN0770005	3.07%
Anthem Bronze Pathway 6000/30%	17575IN0770063	Off	Bronze	0.8809	IN IND:-:Pathway HMO/POS	8	17575IN0770005	-1.80%
Anthem Bronze Pathway 6000/30%	17575IN0770064	Off	Bronze	0.8810	IN IND:-:Pathway HMO/POS	9	17575IN0770005	3.83%
Anthem Bronze Pathway 6000/30%	17575IN0770065	Off	Bronze	0.8790	IN IND:-:Pathway HMO/POS	10	17575IN0770005	0.40%
Anthem Bronze Pathway 6000/30%	17575IN0770066	Off	Bronze	0.8787	IN IND:-:Pathway HMO/POS	11	17575IN0770005	1.62%
Anthem Bronze Pathway 6000/30%	17575IN0770067	Off	Bronze	0.8741	IN IND:-:Pathway HMO/POS	12	17575IN0770005	9.97%
Anthem Bronze Pathway 6000/30%	17575IN0770068	Off	Bronze	0.8677	IN IND:-:Pathway HMO/POS	13	17575IN0770005	2.29%
Anthem Bronze Pathway 6000/30%	17575IN0770069	Off	Bronze	0.8476	IN IND:-:Pathway HMO/POS	14	17575IN0770005	-3.57%
Anthem Bronze Pathway 6000/30%	17575IN0770070	Off	Bronze	0.8705	IN IND:-:Pathway HMO/POS	15	17575IN0770005	-2.53%
Anthem Bronze Pathway 6000/30%	17575IN0770071	Off	Bronze	0.8202	IN IND:-:Pathway HMO/POS	16	17575IN0770005	-1.13%

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Bronze Pathway 6000/30%	17575IN0770072	Off	Bronze	0.8783	IN IND:-:Pathway HMO/POS	17	17575IN0770005	3.22%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770015	Off	Bronze	0.8736	IN IND:-:Pathway HMO/POS	1	17575IN0770001	11.13%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770073	Off	Bronze	0.8874	IN IND:-:Pathway HMO/POS	2	17575IN0770001	12.18%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770074	Off	Bronze	0.8914	IN IND:-:Pathway HMO/POS	3	17575IN0770001	6.40%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770075	Off	Bronze	0.8922	IN IND:-:Pathway HMO/POS	4	17575IN0770001	15.01%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770076	Off	Bronze	0.8723	IN IND:-:Pathway HMO/POS	5	17575IN0770001	15.96%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770077	Off	Bronze	0.8759	IN IND:-:Pathway HMO/POS	6	17575IN0770001	12.49%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770078	Off	Bronze	0.8729	IN IND:-:Pathway HMO/POS	7	17575IN0770001	9.44%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770079	Off	Bronze	0.8730	IN IND:-:Pathway HMO/POS	8	17575IN0770001	4.26%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770080	Off	Bronze	0.8730	IN IND:-:Pathway HMO/POS	9	17575IN0770001	10.24%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770081	Off	Bronze	0.8710	IN IND:-:Pathway HMO/POS	10	17575IN0770001	6.61%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770082	Off	Bronze	0.8708	IN IND:-:Pathway HMO/POS	11	17575IN0770001	7.90%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770083	Off	Bronze	0.8662	IN IND:-:Pathway HMO/POS	12	17575IN0770001	16.77%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770084	Off	Bronze	0.8599	IN IND:-:Pathway HMO/POS	13	17575IN0770001	8.61%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770085	Off	Bronze	0.8400	IN IND:-:Pathway HMO/POS	14	17575IN0770001	2.39%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770086	Off	Bronze	0.8627	IN IND:-:Pathway HMO/POS	15	17575IN0770001	3.50%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770087	Off	Bronze	0.8128	IN IND:-:Pathway HMO/POS	16	17575IN0770001	4.98%
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770088	Off	Bronze	0.8704	IN IND:-:Pathway HMO/POS	17	17575IN0770001	9.60%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770016	Off	Bronze	0.8980	IN IND:-:Pathway HMO/POS	1	17575IN0770002	11.19%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770089	Off	Bronze	0.9122	IN IND:-:Pathway HMO/POS	2	17575IN0770002	12.24%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770090	Off	Bronze	0.9163	IN IND:-:Pathway HMO/POS	3	17575IN0770002	6.45%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770091	Off	Bronze	0.9171	IN IND:-:Pathway HMO/POS	4	17575IN0770002	15.06%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770092	Off	Bronze	0.8967	IN IND:-:Pathway HMO/POS	5	17575IN0770002	16.01%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770093	Off	Bronze	0.9004	IN IND:-:Pathway HMO/POS	6	17575IN0770002	12.54%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770094	Off	Bronze	0.8973	IN IND:-:Pathway HMO/POS	7	17575IN0770002	9.50%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770095	Off	Bronze	0.8974	IN IND:-:Pathway HMO/POS	8	17575IN0770002	4.31%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770096	Off	Bronze	0.8974	IN IND:-:Pathway HMO/POS	9	17575IN0770002	10.29%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770097	Off	Bronze	0.8954	IN IND:-:Pathway HMO/POS	10	17575IN0770002	6.66%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770098	Off	Bronze	0.8951	IN IND:-:Pathway HMO/POS	11	17575IN0770002	7.95%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770099	Off	Bronze	0.8904	IN IND:-:Pathway HMO/POS	12	17575IN0770002	16.82%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770100	Off	Bronze	0.8839	IN IND:-:Pathway HMO/POS	13	17575IN0770002	8.66%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770101	Off	Bronze	0.8635	IN IND:-:Pathway HMO/POS	14	17575IN0770002	2.44%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770102	Off	Bronze	0.8868	IN IND:-:Pathway HMO/POS	15	17575IN0770002	3.55%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770103	Off	Bronze	0.8356	IN IND:-:Pathway HMO/POS	16	17575IN0770002	5.03%
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770104	Off	Bronze	0.8947	IN IND:-:Pathway HMO/POS	17	17575IN0770002	9.65%
Anthem Silver Pathway 2850/15%	17575IN0770022	Off	Silver	1.1051	IN IND:-:Pathway HMO/POS	1	17575IN0770009	11.81%
Anthem Silver Pathway 2850/15%	17575IN0770105	Off	Silver	1.1226	IN IND:-:Pathway HMO/POS	2	17575IN0770009	12.86%
Anthem Silver Pathway 2850/15%	17575IN0770106	Off	Silver	1.1277	IN IND:-:Pathway HMO/POS	3	17575IN0770009	7.05%
Anthem Silver Pathway 2850/15%	17575IN0770107	Off	Silver	1.1287	IN IND:-:Pathway HMO/POS	4	17575IN0770009	15.71%
Anthem Silver Pathway 2850/15%	17575IN0770108	Off	Silver	1.1035	IN IND:-:Pathway HMO/POS	5	17575IN0770009	16.66%
Anthem Silver Pathway 2850/15%	17575IN0770109	Off	Silver	1.1081	IN IND:-:Pathway HMO/POS	6	17575IN0770009	13.17%
Anthem Silver Pathway 2850/15%	17575IN0770110	Off	Silver	1.1043	IN IND:-:Pathway HMO/POS	7	17575IN0770009	10.11%
Anthem Silver Pathway 2850/15%	17575IN0770111	Off	Silver	1.1044	IN IND:-:Pathway HMO/POS	8	17575IN0770009	4.90%

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Silver Pathway 2850/15%	17575IN0770112	Off	Silver	1.1044	IN IND:-:Pathway HMO/POS	9	17575IN0770009	10.91%
Anthem Silver Pathway 2850/15%	17575IN0770113	Off	Silver	1.1019	IN IND:-:Pathway HMO/POS	10	17575IN0770009	7.25%
Anthem Silver Pathway 2850/15%	17575IN0770114	Off	Silver	1.1016	IN IND:-:Pathway HMO/POS	11	17575IN0770009	8.55%
Anthem Silver Pathway 2850/15%	17575IN0770115	Off	Silver	1.0958	IN IND:-:Pathway HMO/POS	12	17575IN0770009	17.48%
Anthem Silver Pathway 2850/15%	17575IN0770116	Off	Silver	1.0878	IN IND:-:Pathway HMO/POS	13	17575IN0770009	9.27%
Anthem Silver Pathway 2850/15%	17575IN0770117	Off	Silver	1.0626	IN IND:-:Pathway HMO/POS	14	17575IN0770009	3.01%
Anthem Silver Pathway 2850/15%	17575IN0770118	Off	Silver	1.0914	IN IND:-:Pathway HMO/POS	15	17575IN0770009	4.13%
Anthem Silver Pathway 2850/15%	17575IN0770119	Off	Silver	1.0283	IN IND:-:Pathway HMO/POS	16	17575IN0770009	5.62%
Anthem Silver Pathway 2850/15%	17575IN0770120	Off	Silver	1.1011	IN IND:-:Pathway HMO/POS	17	17575IN0770009	10.27%
Anthem Silver Pathway 2500/10%	17575IN0770019	Off	Silver	1.1663	IN IND:-:Pathway HMO/POS	1	17575IN0770006	12.57%
Anthem Silver Pathway 2500/10%	17575IN0770121	Off	Silver	1.1848	IN IND:-:Pathway HMO/POS	2	17575IN0770006	13.63%
Anthem Silver Pathway 2500/10%	17575IN0770122	Off	Silver	1.1901	IN IND:-:Pathway HMO/POS	3	17575IN0770006	7.78%
Anthem Silver Pathway 2500/10%	17575IN0770123	Off	Silver	1.1911	IN IND:-:Pathway HMO/POS	4	17575IN0770006	16.49%
Anthem Silver Pathway 2500/10%	17575IN0770124	Off	Silver	1.1646	IN IND:-:Pathway HMO/POS	5	17575IN0770006	17.45%
Anthem Silver Pathway 2500/10%	17575IN0770125	Off	Silver	1.1694	IN IND:-:Pathway HMO/POS	6	17575IN0770006	13.94%
Anthem Silver Pathway 2500/10%	17575IN0770126	Off	Silver	1.1654	IN IND:-:Pathway HMO/POS	7	17575IN0770006	10.86%
Anthem Silver Pathway 2500/10%	17575IN0770127	Off	Silver	1.1655	IN IND:-:Pathway HMO/POS	8	17575IN0770006	5.61%
Anthem Silver Pathway 2500/10%	17575IN0770128	Off	Silver	1.1655	IN IND:-:Pathway HMO/POS	9	17575IN0770006	11.67%
Anthem Silver Pathway 2500/10%	17575IN0770129	Off	Silver	1.1629	IN IND:-:Pathway HMO/POS	10	17575IN0770006	7.98%
Anthem Silver Pathway 2500/10%	17575IN0770130	Off	Silver	1.1626	IN IND:-:Pathway HMO/POS	11	17575IN0770006	9.29%
Anthem Silver Pathway 2500/10%	17575IN0770131	Off	Silver	1.1564	IN IND:-:Pathway HMO/POS	12	17575IN0770006	18.28%
Anthem Silver Pathway 2500/10%	17575IN0770132	Off	Silver	1.1480	IN IND:-:Pathway HMO/POS	13	17575IN0770006	10.01%
Anthem Silver Pathway 2500/10%	17575IN0770133	Off	Silver	1.1214	IN IND:-:Pathway HMO/POS	14	17575IN0770006	3.71%
Anthem Silver Pathway 2500/10%	17575IN0770134	Off	Silver	1.1518	IN IND:-:Pathway HMO/POS	15	17575IN0770006	4.83%
Anthem Silver Pathway 2500/10%	17575IN0770135	Off	Silver	1.0852	IN IND:-:Pathway HMO/POS	16	17575IN0770006	6.33%
Anthem Silver Pathway 2500/10%	17575IN0770136	Off	Silver	1.1620	IN IND:-:Pathway HMO/POS	17	17575IN0770006	11.02%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770020	Off	Silver	1.1196	IN IND:-:Pathway HMO/POS	1	17575IN0770007	13.87%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770137	Off	Silver	1.1374	IN IND:-:Pathway HMO/POS	2	17575IN0770007	14.94%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770138	Off	Silver	1.1425	IN IND:-:Pathway HMO/POS	3	17575IN0770007	9.02%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770139	Off	Silver	1.1435	IN IND:-:Pathway HMO/POS	4	17575IN0770007	17.84%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770140	Off	Silver	1.1180	IN IND:-:Pathway HMO/POS	5	17575IN0770007	18.81%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770141	Off	Silver	1.1226	IN IND:-:Pathway HMO/POS	6	17575IN0770007	15.26%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770142	Off	Silver	1.1188	IN IND:-:Pathway HMO/POS	7	17575IN0770007	12.14%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770143	Off	Silver	1.1189	IN IND:-:Pathway HMO/POS	8	17575IN0770007	6.83%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770144	Off	Silver	1.1189	IN IND:-:Pathway HMO/POS	9	17575IN0770007	12.95%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770145	Off	Silver	1.1164	IN IND:-:Pathway HMO/POS	10	17575IN0770007	9.23%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770146	Off	Silver	1.1161	IN IND:-:Pathway HMO/POS	11	17575IN0770007	10.55%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770147	Off	Silver	1.1102	IN IND:-:Pathway HMO/POS	12	17575IN0770007	19.64%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770148	Off	Silver	1.1020	IN IND:-:Pathway HMO/POS	13	17575IN0770007	11.28%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770149	Off	Silver	1.0766	IN IND:-:Pathway HMO/POS	14	17575IN0770007	4.91%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770150	Off	Silver	1.1057	IN IND:-:Pathway HMO/POS	15	17575IN0770007	6.04%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770151	Off	Silver	1.0418	IN IND:-:Pathway HMO/POS	16	17575IN0770007	7.56%
Anthem Silver Pathway 2500/10% for HSA	17575IN0770152	Off	Silver	1.1155	IN IND:-:Pathway HMO/POS	17	17575IN0770007	12.30%

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Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Silver Pathway 1750/20%	17575IN0770021	Off	Silver	1.1583	IN IND:-:Pathway HMO/POS	1	17575IN0770008	12.33%
Anthem Silver Pathway 1750/20%	17575IN0770153	Off	Silver	1.1766	IN IND:-:Pathway HMO/POS	2	17575IN0770008	13.40%
Anthem Silver Pathway 1750/20%	17575IN0770154	Off	Silver	1.1819	IN IND:-:Pathway HMO/POS	3	17575IN0770008	7.55%
Anthem Silver Pathway 1750/20%	17575IN0770155	Off	Silver	1.1829	IN IND:-:Pathway HMO/POS	4	17575IN0770008	16.25%
Anthem Silver Pathway 1750/20%	17575IN0770156	Off	Silver	1.1566	IN IND:-:Pathway HMO/POS	5	17575IN0770008	17.21%
Anthem Silver Pathway 1750/20%	17575IN0770157	Off	Silver	1.1613	IN IND:-:Pathway HMO/POS	6	17575IN0770008	13.71%
Anthem Silver Pathway 1750/20%	17575IN0770158	Off	Silver	1.1574	IN IND:-:Pathway HMO/POS	7	17575IN0770008	10.63%
Anthem Silver Pathway 1750/20%	17575IN0770159	Off	Silver	1.1575	IN IND:-:Pathway HMO/POS	8	17575IN0770008	5.39%
Anthem Silver Pathway 1750/20%	17575IN0770160	Off	Silver	1.1575	IN IND:-:Pathway HMO/POS	9	17575IN0770008	11.43%
Anthem Silver Pathway 1750/20%	17575IN0770161	Off	Silver	1.1549	IN IND:-:Pathway HMO/POS	10	17575IN0770008	7.76%
Anthem Silver Pathway 1750/20%	17575IN0770162	Off	Silver	1.1546	IN IND:-:Pathway HMO/POS	11	17575IN0770008	9.06%
Anthem Silver Pathway 1750/20%	17575IN0770163	Off	Silver	1.1484	IN IND:-:Pathway HMO/POS	12	17575IN0770008	18.03%
Anthem Silver Pathway 1750/20%	17575IN0770164	Off	Silver	1.1401	IN IND:-:Pathway HMO/POS	13	17575IN0770008	9.78%
Anthem Silver Pathway 1750/20%	17575IN0770165	Off	Silver	1.1137	IN IND:-:Pathway HMO/POS	14	17575IN0770008	3.50%
Anthem Silver Pathway 1750/20%	17575IN0770166	Off	Silver	1.1438	IN IND:-:Pathway HMO/POS	15	17575IN0770008	4.62%
Anthem Silver Pathway 1750/20%	17575IN0770167	Off	Silver	1.0777	IN IND:-:Pathway HMO/POS	16	17575IN0770008	6.11%
Anthem Silver Pathway 1750/20%	17575IN0770168	Off	Silver	1.1540	IN IND:-:Pathway HMO/POS	17	17575IN0770008	10.78%
Anthem Gold Pathway 1250/10%	17575IN0770023	Off	Gold	1.3092	IN IND:-:Pathway HMO/POS	1	17575IN0770010	8.87%
Anthem Gold Pathway 1250/10%	17575IN0770169	Off	Gold	1.3300	IN IND:-:Pathway HMO/POS	2	17575IN0770010	9.90%
Anthem Gold Pathway 1250/10%	17575IN0770170	Off	Gold	1.3360	IN IND:-:Pathway HMO/POS	3	17575IN0770010	4.23%
Anthem Gold Pathway 1250/10%	17575IN0770171	Off	Gold	1.3371	IN IND:-:Pathway HMO/POS	4	17575IN0770010	12.66%
Anthem Gold Pathway 1250/10%	17575IN0770172	Off	Gold	1.3073	IN IND:-:Pathway HMO/POS	5	17575IN0770010	13.59%
Anthem Gold Pathway 1250/10%	17575IN0770173	Off	Gold	1.3127	IN IND:-:Pathway HMO/POS	6	17575IN0770010	10.20%
Anthem Gold Pathway 1250/10%	17575IN0770174	Off	Gold	1.3082	IN IND:-:Pathway HMO/POS	7	17575IN0770010	7.21%
Anthem Gold Pathway 1250/10%	17575IN0770175	Off	Gold	1.3083	IN IND:-:Pathway HMO/POS	8	17575IN0770010	2.14%
Anthem Gold Pathway 1250/10%	17575IN0770176	Off	Gold	1.3084	IN IND:-:Pathway HMO/POS	9	17575IN0770010	8.00%
Anthem Gold Pathway 1250/10%	17575IN0770177	Off	Gold	1.3055	IN IND:-:Pathway HMO/POS	10	17575IN0770010	4.43%
Anthem Gold Pathway 1250/10%	17575IN0770178	Off	Gold	1.3051	IN IND:-:Pathway HMO/POS	11	17575IN0770010	5.70%
Anthem Gold Pathway 1250/10%	17575IN0770179	Off	Gold	1.2982	IN IND:-:Pathway HMO/POS	12	17575IN0770010	14.39%
Anthem Gold Pathway 1250/10%	17575IN0770180	Off	Gold	1.2887	IN IND:-:Pathway HMO/POS	13	17575IN0770010	6.39%
Anthem Gold Pathway 1250/10%	17575IN0770181	Off	Gold	1.2589	IN IND:-:Pathway HMO/POS	14	17575IN0770010	0.30%
Anthem Gold Pathway 1250/10%	17575IN0770182	Off	Gold	1.2929	IN IND:-:Pathway HMO/POS	15	17575IN0770010	1.39%
Anthem Gold Pathway 1250/10%	17575IN0770183	Off	Gold	1.2182	IN IND:-:Pathway HMO/POS	16	17575IN0770010	2.84%
Anthem Gold Pathway 1250/10%	17575IN0770184	Off	Gold	1.3045	IN IND:-:Pathway HMO/POS	17	17575IN0770010	7.37%
Anthem Bronze Pathway POS 5000/40%	17575IN0780005	Off	Bronze	0.8809	IN IND:-:Pathway HMO/POS	1	17575IN0780001	13.67%
Anthem Bronze Pathway POS 5000/40%	17575IN0780006	Off	Bronze	0.8949	IN IND:-:Pathway HMO/POS	2	17575IN0780001	14.75%
Anthem Bronze Pathway POS 5000/40%	17575IN0780007	Off	Bronze	0.8989	IN IND:-:Pathway HMO/POS	3	17575IN0780001	8.83%
Anthem Bronze Pathway POS 5000/40%	17575IN0780008	Off	Bronze	0.8997	IN IND:-:Pathway HMO/POS	4	17575IN0780001	17.64%
Anthem Bronze Pathway POS 5000/40%	17575IN0780009	Off	Bronze	0.8796	IN IND:-:Pathway HMO/POS	5	17575IN0780001	18.61%
Anthem Bronze Pathway POS 5000/40%	17575IN0780010	Off	Bronze	0.8832	IN IND:-:Pathway HMO/POS	6	17575IN0780001	15.06%
Anthem Bronze Pathway POS 5000/40%	17575IN0780011	Off	Bronze	0.8802	IN IND:-:Pathway HMO/POS	7	17575IN0780001	11.95%
Anthem Bronze Pathway POS 5000/40%	17575IN0780012	Off	Bronze	0.8803	IN IND:-:Pathway HMO/POS	8	17575IN0780001	6.65%
Anthem Bronze Pathway POS 5000/40%	17575IN0780013	Off	Bronze	0.8803	IN IND:-:Pathway HMO/POS	9	17575IN0780001	12.76%

Exhibit I - Non-Grandfathered Benefit Plan Factors and Rate Increases

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	2015 HIOS Plan ID	On/Off Exchange	Metal Level	Benefit Plan Factor	Network Name	Area(s) Offered	2014 HIOS Plan ID Mapping	Plan Specific Rate Increase* (excluding aging)
Anthem Bronze Pathway POS 5000/40%	17575IN0780014	Off	Bronze	0.8784	IN IND:-:Pathway HMO/POS	10	17575IN0780001	9.04%
Anthem Bronze Pathway POS 5000/40%	17575IN0780015	Off	Bronze	0.8781	IN IND:-:Pathway HMO/POS	11	17575IN0780001	10.36%
Anthem Bronze Pathway POS 5000/40%	17575IN0780016	Off	Bronze	0.8735	IN IND:-:Pathway HMO/POS	12	17575IN0780001	19.44%
Anthem Bronze Pathway POS 5000/40%	17575IN0780017	Off	Bronze	0.8671	IN IND:-:Pathway HMO/POS	13	17575IN0780001	11.09%
Anthem Bronze Pathway POS 5000/40%	17575IN0780018	Off	Bronze	0.8470	IN IND:-:Pathway HMO/POS	14	17575IN0780001	4.73%
Anthem Bronze Pathway POS 5000/40%	17575IN0780019	Off	Bronze	0.8699	IN IND:-:Pathway HMO/POS	15	17575IN0780001	5.86%
Anthem Bronze Pathway POS 5000/40%	17575IN0780020	Off	Bronze	0.8197	IN IND:-:Pathway HMO/POS	16	17575IN0780001	7.38%
Anthem Bronze Pathway POS 5000/40%	17575IN0780021	Off	Bronze	0.8777	IN IND:-:Pathway HMO/POS	17	17575IN0780001	12.11%
Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan	17575IN0930005	On	Silver	1.0478	IN IND:-:Pathway X HMO/POS	All	17575IN0930001	4.47%
Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan	17575IN0930006	On	Gold	1.2217	IN IND:-:Pathway X HMO/POS	All	17575IN0930002	-2.66%

NOTES:

Benefit Plan Factors above reflect plan by plan differences from the index rate for allowable adjustments as described in detail in the Market Reform and Payment Parameters Regulations and illustrated in Exhibit O. The weighted average of these adjustments for the entire risk pool included in this rate filing is detailed in Exhibit H.

Plan level increases in rates do not include demographic changes in the population.

Exhibit J - Age and Tobacco Factors

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Age	Age Rating Factor	Tobacco Rating Factor
0-17	0.635	1.000
18	0.635	1.050
19	0.635	1.050
20	0.635	1.050
21	1.000	1.050
22	1.000	1.050
23	1.000	1.050
24	1.000	1.050
25	1.004	1.100
26	1.024	1.100
27	1.048	1.100
28	1.087	1.100
29	1.119	1.100
30	1.135	1.150
31	1.159	1.150
32	1.183	1.150
33	1.198	1.150
34	1.214	1.150
35	1.222	1.200
36	1.230	1.200
37	1.238	1.200
38	1.246	1.200
39	1.262	1.200
40	1.278	1.250
41	1.302	1.250
42	1.325	1.250
43	1.357	1.250
44	1.397	1.250
45	1.444	1.300
46	1.500	1.300
47	1.563	1.300
48	1.635	1.300
49	1.706	1.300
50	1.786	1.400
51	1.865	1.400
52	1.952	1.400
53	2.040	1.400
54	2.135	1.400
55	2.230	1.490
56	2.333	1.490
57	2.437	1.490
58	2.548	1.490
59	2.603	1.490
60	2.714	1.490
61	2.810	1.490
62	2.873	1.490
63	2.952	1.490
64+	3.000	1.490

NOTES:

{1} The weighted averages of these factors for the entire risk pool included in this rate filing is detailed in Exhibit H.

Exhibit K - Area Factors

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Rating Area Description	Area Rating Factor
Region 1	0.9706
Region 2	0.9827
Region 3	1.0236
Region 4	1.0141
Region 5	0.9609
Region 6	1.0054
Region 7	1.0053
Region 8	0.9845
Region 9	0.9882
Region 10	1.0617
Region 11	1.0148
Region 12	1.0452
Region 13	1.0260
Region 14	0.9731
Region 15	0.9571
Region 16	0.7828
Region 17	1.0147
OOA	1.2765

NOTES:

{1} The weighted average of these factors for the entire risk pool included in this rate filing is detailed in Exhibit H.

{2} OOA = Out of Area

Exhibit L - Sample Rate Calculation

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Name: **John Doe**
Effective Date: **1/1/2015**
On/Off Exchange: On/Off
Metal Level: **Bronze**
Plan ID: 17575IN0700024
Rating Area: **Region 1**

Family Members Covered:

	Age	Smoker?
Subscriber	47	N
Spouse	42	N
Child (age 21+)	25	Y
Child #1	20	N
Child #2	16	N

Calculation of Monthly Premium:

Base Rate =	$280.15	Exhibit A
x Benefit Plan Factor	0.7962	Exhibit I
x Area Factor	0.9706	Exhibit K
Base Rate Adjusted for Plan/Area =	$216.50	

Age/Tobacco Factors: Exhibit J

	Age Factor	Tobacco Factor
Subscriber	1.563	1.000
Spouse	1.325	1.000
Child (age 21+)	1.004	1.100
Child #1	0.635	1.000
Child #2	0.635	1.000

Final Monthly Premium PMPM:

	PMPM
Subscriber	$ 338.39
Spouse	$ 286.86
Child (age 21+)	$ 239.10
Child #1	$ 137.48
Child #2	$ 137.48
TOTAL	**$ 1,139.31**

NOTES:

{1} As per the Market Reform Rule, when computing family premiums no more than the three oldest covered children under the age of 21 are taken into account whereas the premiums associated with each child age 21+ are included.

{2} Minor rate variances may occur due to differences in rounding methodology.

Exhibit M - Federal MLR Estimated Calculation

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Numerator:			
Incurred Claims	$	430.18	Exhibit A
+ Quality Improvement Expense	$	3.98	Exhibit G
+ Risk Corridor Contributions	$	-	
+ Risk Adjustment Net Transfer	$	-	Exhibit F
+ Reinsurance Receipts	$	(34.30)	Exhibit F
+ Risk Corridor Receipts	$	-	
+ Reduction to Rx Incurred Claims (ACA MLR)	$	(7.09)	
= *Estimated* Federal MLR Numerator	$	392.77	
Denominator:			
Premiums	$	494.55	Exhibit A
- Federal and State Taxes	$	9.59	Exhibit A (Line 13) x Exhibit G (Income Taxes)
- Premium Taxes	$	-	Exhibit A (Line 13) x Exhibit G (Premium Tax)
- Risk Adjustment User Fee	$	0.08	Exhibit F
- Reinsurance Contributions	$	3.67	Exhibit F
- Licensing and Regulatory Fees	$	31.83	Exhibit A (Line 13) x Exhibit G (Fees)
= *Estimated* Federal MLR Denominator	$	449.38	
***Estimated* Federal MLR**		**87.40%**	

NOTES:

The above calculation is purely an estimate and not meant to be compared to the minimum MLR benchmark for federal/state MLR rebate purposes:

{1} The above calculation represents only the products in this filing. Federal MLR will be calculated at the legal entity and market level.

{2} Not all numerator/denominator components are captured above (for example, fraud and prevention program costs, payroll taxes, assessments for state high risk pools etc.).

{3} Other adjustments may also be applied within the federal MLR calculation such as 3-year averaging, new business, credibility, deductible and dual option. These are ignored in the above calculation.

{4} Licensing and Regulatory Fees include ACA-related fees as allowed under the MLR Final Rule.

Exhibit N - Market Adjusted Index Rate Development

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

1)	Projected Paid Claim Cost	$	434.85	Exhibit A, Line Item 8
2)	- Non-EHBs Embedded in Line Item 1) Above	$	-	
3)	= Projected Paid Claims, Excluding ALL Non-EHBs	$	434.85	
4)	+ Rx Rebates	$	(5.97)	Exhibit E
5)	+ Additional EHBs {1}	$	1.30	Exhibit E
6)	= Projected Paid Claims Reflecting only EHBs	$	430.18	
7)	÷ Paid to Allowed Ratio		0.6854	
8)	= Projected Allowed Claims Reflecting only EHBs	**$**	**627.63**	**= Index Rate**
9)	Reinsurance Contribution	$	3.67	Exhibit F
10)	Expected Reinsurance Payments	$	(34.30)	Exhibit F
11)	Risk Adjustment Fee	$	0.08	Exhibit F
12)	Risk Adjustment Net Transfer	$	-	Exhibit F
13)	Exchange Fee	$	12.91	
14)	**Market Adjusted Index Rate**	$	601.89	= [(6) + (9) + (10) + (11) + (12) + (13)] ÷ (7)

NOTE:

{1} Pediatric Dental and Pediatric Vision

{2} The Market Adjusted Index Rate is the same for all plans in the single risk pool

Exhibit O - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit N)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Consumer Adjusted Premium Rate {4}
Anthem Catastrophic DirectAccess	17575IN0700014	$601.89	0.5701	0.9797	1.0000	0.7586	$52.58	$307.62	1.7079	$180.12
Anthem Bronze DirectAccess w/HSA caar	17575IN0700024	$601.89	0.5349	0.9797	1.0000	1.0015	$65.08	$380.98	1.7079	$223.07
Anthem Bronze DirectAccess caae	17575IN0700023	$601.89	0.5717	0.9797	1.0000	1.0015	$69.55	$407.16	1.7079	$238.40
Anthem Bronze DirectAccess caaa	17575IN0700020	$601.89	0.5778	0.9797	1.0000	1.0015	$70.30	$411.54	1.7079	$240.96
Anthem Bronze DirectAccess w/HSA cabm	17575IN0700025	$601.89	0.5360	0.9797	1.0000	1.0015	$65.24	$381.77	1.7079	$223.53
Anthem Bronze DirectAccess cabr	17575IN0700021	$601.89	0.5783	0.9797	1.0000	1.0015	$70.37	$411.90	1.7079	$241.17
Anthem Silver DirectAccess cbaa	17575IN0700026	$601.89	0.7194	0.9797	1.0000	1.0015	$87.52	$512.36	1.7079	$299.99
Anthem Silver DirectAccess w/HSA cbbg	17575IN0700028	$601.89	0.6632	0.9797	1.0000	1.0015	$80.70	$472.36	1.7079	$276.57
Anthem Silver DirectAccess cbds	17575IN0700027	$601.89	0.7157	0.9797	1.0000	1.0015	$87.10	$509.80	1.7079	$298.49
Anthem Bronze DirectAccess caca	17575IN0760002	$601.89	0.5435	0.9797	1.0000	1.0015	$66.14	$387.12	1.7079	$226.66
Anthem Bronze Pathway 5750/20%	17575IN0770017	$601.89	0.5790	1.0648	1.0000	1.0015	$76.54	$448.17	1.7079	$262.41
Anthem Bronze Pathway 5750/20%	17575IN0770041	$601.89	0.5790	1.0816	1.0000	1.0015	$77.75	$455.27	1.7079	$266.56
Anthem Bronze Pathway 5750/20%	17575IN0770042	$601.89	0.5790	1.0865	1.0000	1.0015	$78.10	$457.32	1.7079	$267.76
Anthem Bronze Pathway 5750/20%	17575IN0770043	$601.89	0.5790	1.0874	1.0000	1.0015	$78.17	$457.71	1.7079	$267.99
Anthem Bronze Pathway 5750/20%	17575IN0770044	$601.89	0.5790	1.0632	1.0000	1.0015	$76.43	$447.52	1.7079	$262.03
Anthem Bronze Pathway 5750/20%	17575IN0770045	$601.89	0.5790	1.0676	1.0000	1.0015	$76.75	$449.36	1.7079	$263.10
Anthem Bronze Pathway 5750/20%	17575IN0770046	$601.89	0.5790	1.0640	1.0000	1.0015	$76.49	$447.83	1.7079	$262.21
Anthem Bronze Pathway 5750/20%	17575IN0770047	$601.89	0.5790	1.0640	1.0000	1.0015	$76.49	$447.86	1.7079	$262.23
Anthem Bronze Pathway 5750/20%	17575IN0770048	$601.89	0.5790	1.0641	1.0000	1.0015	$76.49	$447.88	1.7079	$262.24
Anthem Bronze Pathway 5750/20%	17575IN0770049	$601.89	0.5790	1.0617	1.0000	1.0015	$76.32	$446.87	1.7079	$261.65
Anthem Bronze Pathway 5750/20%	17575IN0770050	$601.89	0.5790	1.0614	1.0000	1.0015	$76.30	$446.74	1.7079	$261.57
Anthem Bronze Pathway 5750/20%	17575IN0770051	$601.89	0.5790	1.0557	1.0000	1.0015	$75.90	$444.38	1.7079	$260.19
Anthem Bronze Pathway 5750/20%	17575IN0770052	$601.89	0.5790	1.0480	1.0000	1.0015	$75.34	$441.13	1.7079	$258.29
Anthem Bronze Pathway 5750/20%	17575IN0770053	$601.89	0.5790	1.0238	1.0000	1.0015	$73.61	$430.93	1.7079	$252.32
Anthem Bronze Pathway 5750/20%	17575IN0770054	$601.89	0.5790	1.0515	1.0000	1.0015	$75.59	$442.59	1.7079	$259.14
Anthem Bronze Pathway 5750/20%	17575IN0770055	$601.89	0.5790	0.9907	1.0000	1.0015	$71.23	$417.01	1.7079	$244.16
Anthem Bronze Pathway 5750/20%	17575IN0770056	$601.89	0.5790	1.0609	1.0000	1.0015	$76.27	$446.54	1.7079	$261.45
Anthem Bronze Pathway 6000/30%	17575IN0770018	$601.89	0.5449	1.0648	1.0000	1.0015	$72.04	$421.79	1.7079	$246.96
Anthem Bronze Pathway 6000/30%	17575IN0770057	$601.89	0.5449	1.0816	1.0000	1.0015	$73.18	$428.47	1.7079	$250.87
Anthem Bronze Pathway 6000/30%	17575IN0770058	$601.89	0.5449	1.0865	1.0000	1.0015	$73.51	$430.40	1.7079	$252.00
Anthem Bronze Pathway 6000/30%	17575IN0770059	$601.89	0.5449	1.0874	1.0000	1.0015	$73.57	$430.76	1.7079	$252.22
Anthem Bronze Pathway 6000/30%	17575IN0770060	$601.89	0.5449	1.0632	1.0000	1.0015	$71.94	$421.18	1.7079	$246.60
Anthem Bronze Pathway 6000/30%	17575IN0770061	$601.89	0.5449	1.0676	1.0000	1.0015	$72.23	$422.90	1.7079	$247.61
Anthem Bronze Pathway 6000/30%	17575IN0770062	$601.89	0.5449	1.0640	1.0000	1.0015	$71.99	$421.47	1.7079	$246.78
Anthem Bronze Pathway 6000/30%	17575IN0770063	$601.89	0.5449	1.0640	1.0000	1.0015	$71.99	$421.50	1.7079	$246.79
Anthem Bronze Pathway 6000/30%	17575IN0770064	$601.89	0.5449	1.0641	1.0000	1.0015	$71.99	$421.51	1.7079	$246.80
Anthem Bronze Pathway 6000/30%	17575IN0770065	$601.89	0.5449	1.0617	1.0000	1.0015	$71.83	$420.57	1.7079	$246.25
Anthem Bronze Pathway 6000/30%	17575IN0770066	$601.89	0.5449	1.0614	1.0000	1.0015	$71.81	$420.45	1.7079	$246.17
Anthem Bronze Pathway 6000/30%	17575IN0770067	$601.89	0.5449	1.0557	1.0000	1.0015	$71.43	$418.22	1.7079	$244.87
Anthem Bronze Pathway 6000/30%	17575IN0770068	$601.89	0.5449	1.0480	1.0000	1.0015	$70.91	$415.16	1.7079	$243.08
Anthem Bronze Pathway 6000/30%	17575IN0770069	$601.89	0.5449	1.0238	1.0000	1.0015	$69.27	$405.57	1.7079	$237.46
Anthem Bronze Pathway 6000/30%	17575IN0770070	$601.89	0.5449	1.0515	1.0000	1.0015	$71.14	$416.53	1.7079	$243.88
Anthem Bronze Pathway 6000/30%	17575IN0770071	$601.89	0.5449	0.9907	1.0000	1.0015	$67.04	$392.46	1.7079	$229.79
Anthem Bronze Pathway 6000/30%	17575IN0770072	$601.89	0.5449	1.0609	1.0000	1.0015	$71.78	$420.25	1.7079	$246.06
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770015	$601.89	0.5400	1.0648	1.0000	1.0015	$71.39	$417.99	1.7079	$244.73
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770073	$601.89	0.5400	1.0816	1.0000	1.0015	$72.52	$424.60	1.7079	$248.61
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770074	$601.89	0.5400	1.0865	1.0000	1.0015	$72.85	$426.51	1.7079	$249.73
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770075	$601.89	0.5400	1.0874	1.0000	1.0015	$72.91	$426.88	1.7079	$249.94
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770076	$601.89	0.5400	1.0632	1.0000	1.0015	$71.29	$417.38	1.7079	$244.38
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770077	$601.89	0.5400	1.0676	1.0000	1.0015	$71.58	$419.09	1.7079	$245.38
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770078	$601.89	0.5400	1.0640	1.0000	1.0015	$71.34	$417.67	1.7079	$244.55
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770079	$601.89	0.5400	1.0640	1.0000	1.0015	$71.34	$417.70	1.7079	$244.57

Exhibit O - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit N)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Consumer Adjusted Premium Rate {4}
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770080	$601.89	0.5400	1.0641	1.0000	1.0015	$71.34	$417.71	1.7079	$244.57
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770081	$601.89	0.5400	1.0617	1.0000	1.0015	$71.19	$416.77	1.7079	$244.03
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770082	$601.89	0.5400	1.0614	1.0000	1.0015	$71.16	$416.65	1.7079	$243.95
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770083	$601.89	0.5400	1.0557	1.0000	1.0015	$70.79	$414.45	1.7079	$242.66
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770084	$601.89	0.5400	1.0480	1.0000	1.0015	$70.27	$411.42	1.7079	$240.89
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770085	$601.89	0.5400	1.0238	1.0000	1.0015	$68.65	$401.91	1.7079	$235.32
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770086	$601.89	0.5400	1.0515	1.0000	1.0015	$70.50	$412.77	1.7079	$241.68
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770087	$601.89	0.5400	0.9907	1.0000	1.0015	$66.44	$388.92	1.7079	$227.72
Anthem Bronze Pathway 6000/0% for HSA	17575IN0770088	$601.89	0.5400	1.0609	1.0000	1.0015	$71.13	$416.46	1.7079	$243.84
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770016	$601.89	0.5551	1.0648	1.0000	1.0015	$73.41	$429.67	1.7079	$251.58
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770089	$601.89	0.5551	1.0816	1.0000	1.0015	$74.57	$436.47	1.7079	$255.56
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770090	$601.89	0.5551	1.0865	1.0000	1.0015	$74.90	$438.44	1.7079	$256.71
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770091	$601.89	0.5551	1.0874	1.0000	1.0015	$74.97	$438.81	1.7079	$256.93
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770092	$601.89	0.5551	1.0632	1.0000	1.0015	$73.30	$429.05	1.7079	$251.21
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770093	$601.89	0.5551	1.0676	1.0000	1.0015	$73.60	$430.80	1.7079	$252.24
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770094	$601.89	0.5551	1.0640	1.0000	1.0015	$73.35	$429.34	1.7079	$251.39
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770095	$601.89	0.5551	1.0640	1.0000	1.0015	$73.36	$429.38	1.7079	$251.40
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770096	$601.89	0.5551	1.0641	1.0000	1.0015	$73.36	$429.39	1.7079	$251.41
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770097	$601.89	0.5551	1.0617	1.0000	1.0015	$73.20	$428.43	1.7079	$250.85
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770098	$601.89	0.5551	1.0614	1.0000	1.0015	$73.18	$428.30	1.7079	$250.77
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770099	$601.89	0.5551	1.0557	1.0000	1.0015	$72.79	$426.03	1.7079	$249.45
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770100	$601.89	0.5551	1.0480	1.0000	1.0015	$72.26	$422.92	1.7079	$247.62
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770101	$601.89	0.5551	1.0238	1.0000	1.0015	$70.59	$413.14	1.7079	$241.90
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770102	$601.89	0.5551	1.0515	1.0000	1.0015	$72.50	$424.32	1.7079	$248.44
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770103	$601.89	0.5551	0.9907	1.0000	1.0015	$68.32	$399.79	1.7079	$234.08
Anthem Bronze Pathway 4000/20% for HSA	17575IN0770104	$601.89	0.5551	1.0609	1.0000	1.0015	$73.14	$428.10	1.7079	$250.66
Anthem Silver Pathway 2850/15%	17575IN0770022	$601.89	0.6831	1.0648	1.0000	1.0015	$90.32	$528.78	1.7079	$309.61
Anthem Silver Pathway 2850/15%	17575IN0770105	$601.89	0.6831	1.0816	1.0000	1.0015	$91.75	$537.15	1.7079	$314.51
Anthem Silver Pathway 2850/15%	17575IN0770106	$601.89	0.6831	1.0865	1.0000	1.0015	$92.16	$539.57	1.7079	$315.92
Anthem Silver Pathway 2850/15%	17575IN0770107	$601.89	0.6831	1.0874	1.0000	1.0015	$92.24	$540.03	1.7079	$316.19
Anthem Silver Pathway 2850/15%	17575IN0770108	$601.89	0.6831	1.0632	1.0000	1.0015	$90.19	$528.02	1.7079	$309.16
Anthem Silver Pathway 2850/15%	17575IN0770109	$601.89	0.6831	1.0676	1.0000	1.0015	$90.56	$530.18	1.7079	$310.42
Anthem Silver Pathway 2850/15%	17575IN0770110	$601.89	0.6831	1.0640	1.0000	1.0015	$90.25	$528.38	1.7079	$309.37
Anthem Silver Pathway 2850/15%	17575IN0770111	$601.89	0.6831	1.0640	1.0000	1.0015	$90.26	$528.42	1.7079	$309.39
Anthem Silver Pathway 2850/15%	17575IN0770112	$601.89	0.6831	1.0641	1.0000	1.0015	$90.26	$528.43	1.7079	$309.40
Anthem Silver Pathway 2850/15%	17575IN0770113	$601.89	0.6831	1.0617	1.0000	1.0015	$90.06	$527.25	1.7079	$308.71
Anthem Silver Pathway 2850/15%	17575IN0770114	$601.89	0.6831	1.0614	1.0000	1.0015	$90.03	$527.10	1.7079	$308.62
Anthem Silver Pathway 2850/15%	17575IN0770115	$601.89	0.6831	1.0557	1.0000	1.0015	$89.56	$524.31	1.7079	$306.99
Anthem Silver Pathway 2850/15%	17575IN0770116	$601.89	0.6831	1.0480	1.0000	1.0015	$88.91	$520.47	1.7079	$304.74
Anthem Silver Pathway 2850/15%	17575IN0770117	$601.89	0.6831	1.0238	1.0000	1.0015	$86.85	$508.44	1.7079	$297.70
Anthem Silver Pathway 2850/15%	17575IN0770118	$601.89	0.6831	1.0515	1.0000	1.0015	$89.20	$522.19	1.7079	$305.75
Anthem Silver Pathway 2850/15%	17575IN0770119	$601.89	0.6831	0.9907	1.0000	1.0015	$84.05	$492.01	1.7079	$288.08
Anthem Silver Pathway 2850/15%	17575IN0770120	$601.89	0.6831	1.0609	1.0000	1.0015	$89.99	$526.85	1.7079	$308.48
Anthem Silver Pathway 2500/10%	17575IN0770019	$601.89	0.7209	1.0648	1.0000	1.0015	$95.32	$558.04	1.7079	$326.74
Anthem Silver Pathway 2500/10%	17575IN0770121	$601.89	0.7209	1.0816	1.0000	1.0015	$96.83	$566.88	1.7079	$331.91
Anthem Silver Pathway 2500/10%	17575IN0770122	$601.89	0.7209	1.0865	1.0000	1.0015	$97.26	$569.43	1.7079	$333.41
Anthem Silver Pathway 2500/10%	17575IN0770123	$601.89	0.7209	1.0874	1.0000	1.0015	$97.34	$569.91	1.7079	$333.69
Anthem Silver Pathway 2500/10%	17575IN0770124	$601.89	0.7209	1.0632	1.0000	1.0015	$95.18	$557.23	1.7079	$326.26
Anthem Silver Pathway 2500/10%	17575IN0770125	$601.89	0.7209	1.0676	1.0000	1.0015	$95.57	$559.51	1.7079	$327.60
Anthem Silver Pathway 2500/10%	17575IN0770126	$601.89	0.7209	1.0640	1.0000	1.0015	$95.25	$557.62	1.7079	$326.49
Anthem Silver Pathway 2500/10%	17575IN0770127	$601.89	0.7209	1.0640	1.0000	1.0015	$95.25	$557.66	1.7079	$326.51
Anthem Silver Pathway 2500/10%	17575IN0770128	$601.89	0.7209	1.0641	1.0000	1.0015	$95.26	$557.67	1.7079	$326.52

Exhibit O - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit N)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Consumer Adjusted Premium Rate {4}
Anthem Silver Pathway 2500/10%	17575IN0770129	$601.89	0.7209	1.0617	1.0000	1.0015	$95.04	$556.43	1.7079	$325.79
Anthem Silver Pathway 2500/10%	17575IN0770130	$601.89	0.7209	1.0614	1.0000	1.0015	$95.02	$556.26	1.7079	$325.70
Anthem Silver Pathway 2500/10%	17575IN0770131	$601.89	0.7209	1.0557	1.0000	1.0015	$94.51	$553.32	1.7079	$323.97
Anthem Silver Pathway 2500/10%	17575IN0770132	$601.89	0.7209	1.0480	1.0000	1.0015	$93.82	$549.27	1.7079	$321.60
Anthem Silver Pathway 2500/10%	17575IN0770133	$601.89	0.7209	1.0238	1.0000	1.0015	$91.66	$536.58	1.7079	$314.17
Anthem Silver Pathway 2500/10%	17575IN0770134	$601.89	0.7209	1.0515	1.0000	1.0015	$94.13	$551.09	1.7079	$322.67
Anthem Silver Pathway 2500/10%	17575IN0770135	$601.89	0.7209	0.9907	1.0000	1.0015	$88.71	$519.24	1.7079	$304.02
Anthem Silver Pathway 2500/10%	17575IN0770136	$601.89	0.7209	1.0609	1.0000	1.0015	$94.97	$556.00	1.7079	$325.55
Anthem Silver Pathway 2500/10% for HSA	17575IN0770020	$601.89	0.6921	1.0648	1.0000	1.0015	$91.51	$535.72	1.7079	$313.67
Anthem Silver Pathway 2500/10% for HSA	17575IN0770137	$601.89	0.6921	1.0816	1.0000	1.0015	$92.96	$544.20	1.7079	$318.63
Anthem Silver Pathway 2500/10% for HSA	17575IN0770138	$601.89	0.6921	1.0865	1.0000	1.0015	$93.38	$546.65	1.7079	$320.07
Anthem Silver Pathway 2500/10% for HSA	17575IN0770139	$601.89	0.6921	1.0874	1.0000	1.0015	$93.46	$547.11	1.7079	$320.34
Anthem Silver Pathway 2500/10% for HSA	17575IN0770140	$601.89	0.6921	1.0632	1.0000	1.0015	$91.38	$534.94	1.7079	$313.21
Anthem Silver Pathway 2500/10% for HSA	17575IN0770141	$601.89	0.6921	1.0676	1.0000	1.0015	$91.76	$537.13	1.7079	$314.49
Anthem Silver Pathway 2500/10% for HSA	17575IN0770142	$601.89	0.6921	1.0640	1.0000	1.0015	$91.44	$535.31	1.7079	$313.43
Anthem Silver Pathway 2500/10% for HSA	17575IN0770143	$601.89	0.6921	1.0640	1.0000	1.0015	$91.45	$535.35	1.7079	$313.45
Anthem Silver Pathway 2500/10% for HSA	17575IN0770144	$601.89	0.6921	1.0641	1.0000	1.0015	$91.45	$535.36	1.7079	$313.46
Anthem Silver Pathway 2500/10% for HSA	17575IN0770145	$601.89	0.6921	1.0617	1.0000	1.0015	$91.25	$534.17	1.7079	$312.76
Anthem Silver Pathway 2500/10% for HSA	17575IN0770146	$601.89	0.6921	1.0614	1.0000	1.0015	$91.22	$534.01	1.7079	$312.67
Anthem Silver Pathway 2500/10% for HSA	17575IN0770147	$601.89	0.6921	1.0557	1.0000	1.0015	$90.74	$531.18	1.7079	$311.01
Anthem Silver Pathway 2500/10% for HSA	17575IN0770148	$601.89	0.6921	1.0480	1.0000	1.0015	$90.08	$527.30	1.7079	$308.74
Anthem Silver Pathway 2500/10% for HSA	17575IN0770149	$601.89	0.6921	1.0238	1.0000	1.0015	$88.00	$515.11	1.7079	$301.60
Anthem Silver Pathway 2500/10% for HSA	17575IN0770150	$601.89	0.6921	1.0515	1.0000	1.0015	$90.38	$529.04	1.7079	$309.76
Anthem Silver Pathway 2500/10% for HSA	17575IN0770151	$601.89	0.6921	0.9907	1.0000	1.0015	$85.16	$498.47	1.7079	$291.86
Anthem Silver Pathway 2500/10% for HSA	17575IN0770152	$601.89	0.6921	1.0609	1.0000	1.0015	$91.18	$533.76	1.7079	$312.52
Anthem Silver Pathway 1750/20%	17575IN0770021	$601.89	0.7159	1.0648	1.0000	1.0015	$94.68	$554.19	1.7079	$324.49
Anthem Silver Pathway 1750/20%	17575IN0770153	$601.89	0.7159	1.0816	1.0000	1.0015	$96.18	$562.97	1.7079	$329.62
Anthem Silver Pathway 1750/20%	17575IN0770154	$601.89	0.7159	1.0865	1.0000	1.0015	$96.61	$565.50	1.7079	$331.11
Anthem Silver Pathway 1750/20%	17575IN0770155	$601.89	0.7159	1.0874	1.0000	1.0015	$96.69	$565.98	1.7079	$331.39
Anthem Silver Pathway 1750/20%	17575IN0770156	$601.89	0.7159	1.0632	1.0000	1.0015	$94.55	$553.39	1.7079	$324.01
Anthem Silver Pathway 1750/20%	17575IN0770157	$601.89	0.7159	1.0676	1.0000	1.0015	$94.93	$555.65	1.7079	$325.34
Anthem Silver Pathway 1750/20%	17575IN0770158	$601.89	0.7159	1.0640	1.0000	1.0015	$94.61	$553.77	1.7079	$324.24
Anthem Silver Pathway 1750/20%	17575IN0770159	$601.89	0.7159	1.0640	1.0000	1.0015	$94.62	$553.81	1.7079	$324.26
Anthem Silver Pathway 1750/20%	17575IN0770160	$601.89	0.7159	1.0641	1.0000	1.0015	$94.62	$553.82	1.7079	$324.27
Anthem Silver Pathway 1750/20%	17575IN0770161	$601.89	0.7159	1.0617	1.0000	1.0015	$94.41	$552.59	1.7079	$323.55
Anthem Silver Pathway 1750/20%	17575IN0770162	$601.89	0.7159	1.0614	1.0000	1.0015	$94.38	$552.42	1.7079	$323.45
Anthem Silver Pathway 1750/20%	17575IN0770163	$601.89	0.7159	1.0557	1.0000	1.0015	$93.88	$549.50	1.7079	$321.74
Anthem Silver Pathway 1750/20%	17575IN0770164	$601.89	0.7159	1.0480	1.0000	1.0015	$93.20	$545.48	1.7079	$319.39
Anthem Silver Pathway 1750/20%	17575IN0770165	$601.89	0.7159	1.0238	1.0000	1.0015	$91.05	$532.88	1.7079	$312.00
Anthem Silver Pathway 1750/20%	17575IN0770166	$601.89	0.7159	1.0515	1.0000	1.0015	$93.51	$547.28	1.7079	$320.44
Anthem Silver Pathway 1750/20%	17575IN0770167	$601.89	0.7159	0.9907	1.0000	1.0015	$88.11	$515.66	1.7079	$301.92
Anthem Silver Pathway 1750/20%	17575IN0770168	$601.89	0.7159	1.0609	1.0000	1.0015	$94.34	$552.17	1.7079	$323.30
Anthem Gold Pathway 1250/10%	17575IN0770023	$601.89	0.8092	1.0648	1.0000	1.0015	$107.03	$626.44	1.7079	$366.79
Anthem Gold Pathway 1250/10%	17575IN0770169	$601.89	0.8092	1.0816	1.0000	1.0015	$108.72	$636.35	1.7079	$372.59
Anthem Gold Pathway 1250/10%	17575IN0770170	$601.89	0.8092	1.0865	1.0000	1.0015	$109.20	$639.22	1.7079	$374.27
Anthem Gold Pathway 1250/10%	17575IN0770171	$601.89	0.8092	1.0874	1.0000	1.0015	$109.30	$639.76	1.7079	$374.59
Anthem Gold Pathway 1250/10%	17575IN0770172	$601.89	0.8092	1.0632	1.0000	1.0015	$106.87	$625.53	1.7079	$366.25
Anthem Gold Pathway 1250/10%	17575IN0770173	$601.89	0.8092	1.0676	1.0000	1.0015	$107.31	$628.09	1.7079	$367.75
Anthem Gold Pathway 1250/10%	17575IN0770174	$601.89	0.8092	1.0640	1.0000	1.0015	$106.94	$625.96	1.7079	$366.51
Anthem Gold Pathway 1250/10%	17575IN0770175	$601.89	0.8092	1.0640	1.0000	1.0015	$106.95	$626.01	1.7079	$366.53
Anthem Gold Pathway 1250/10%	17575IN0770176	$601.89	0.8092	1.0641	1.0000	1.0015	$106.95	$626.02	1.7079	$366.54
Anthem Gold Pathway 1250/10%	17575IN0770177	$601.89	0.8092	1.0617	1.0000	1.0015	$106.72	$624.62	1.7079	$365.72

Exhibit O - Plan Adjusted Index Rate and Consumer Adjusted Premium Rates

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

HIOS Plan Name	HIOS Plan ID	Market Adjusted Index Rate (Exhibit N)	Cost Sharing Adjustment	Provider Network Adjustment	Adjustment for Benefits in Addition to the EHBS	Catastrophic Plan Adjustment {1}	Administrative Costs	Plan Adjusted Index Rate {2}	Calibration Factor {3}	Consumer Adjusted Premium Rate {4}
Anthem Gold Pathway 1250/10%	17575IN0770178	$601.89	0.8092	1.0614	1.0000	1.0015	$106.69	$624.44	1.7079	$365.61
Anthem Gold Pathway 1250/10%	17575IN0770179	$601.89	0.8092	1.0557	1.0000	1.0015	$106.12	$621.13	1.7079	$363.68
Anthem Gold Pathway 1250/10%	17575IN0770180	$601.89	0.8092	1.0480	1.0000	1.0015	$105.35	$616.59	1.7079	$361.02
Anthem Gold Pathway 1250/10%	17575IN0770181	$601.89	0.8092	1.0238	1.0000	1.0015	$102.92	$602.34	1.7079	$352.68
Anthem Gold Pathway 1250/10%	17575IN0770182	$601.89	0.8092	1.0515	1.0000	1.0015	$105.69	$618.63	1.7079	$362.21
Anthem Gold Pathway 1250/10%	17575IN0770183	$601.89	0.8092	0.9907	1.0000	1.0015	$99.60	$582.88	1.7079	$341.28
Anthem Gold Pathway 1250/10%	17575IN0770184	$601.89	0.8092	1.0609	1.0000	1.0015	$106.64	$624.15	1.7079	$365.45
Anthem Bronze Pathway POS 5000/40%	17575IN0780005	$601.89	0.5445	1.0648	1.0000	1.0015	$72.00	$421.49	1.7079	$246.79
Anthem Bronze Pathway POS 5000/40%	17575IN0780006	$601.89	0.5445	1.0816	1.0000	1.0015	$73.14	$428.17	1.7079	$250.70
Anthem Bronze Pathway POS 5000/40%	17575IN0780007	$601.89	0.5445	1.0865	1.0000	1.0015	$73.47	$430.09	1.7079	$251.82
Anthem Bronze Pathway POS 5000/40%	17575IN0780008	$601.89	0.5445	1.0874	1.0000	1.0015	$73.53	$430.46	1.7079	$252.04
Anthem Bronze Pathway POS 5000/40%	17575IN0780009	$601.89	0.5445	1.0632	1.0000	1.0015	$71.90	$420.88	1.7079	$246.43
Anthem Bronze Pathway POS 5000/40%	17575IN0780010	$601.89	0.5445	1.0676	1.0000	1.0015	$72.19	$422.61	1.7079	$247.44
Anthem Bronze Pathway POS 5000/40%	17575IN0780011	$601.89	0.5445	1.0640	1.0000	1.0015	$71.95	$421.17	1.7079	$246.60
Anthem Bronze Pathway POS 5000/40%	17575IN0780012	$601.89	0.5445	1.0640	1.0000	1.0015	$71.95	$421.20	1.7079	$246.62
Anthem Bronze Pathway POS 5000/40%	17575IN0780013	$601.89	0.5445	1.0641	1.0000	1.0015	$71.95	$421.21	1.7079	$246.62
Anthem Bronze Pathway POS 5000/40%	17575IN0780014	$601.89	0.5445	1.0617	1.0000	1.0015	$71.79	$420.27	1.7079	$246.07
Anthem Bronze Pathway POS 5000/40%	17575IN0780015	$601.89	0.5445	1.0614	1.0000	1.0015	$71.77	$420.15	1.7079	$246.00
Anthem Bronze Pathway POS 5000/40%	17575IN0780016	$601.89	0.5445	1.0557	1.0000	1.0015	$71.39	$417.93	1.7079	$244.70
Anthem Bronze Pathway POS 5000/40%	17575IN0780017	$601.89	0.5445	1.0480	1.0000	1.0015	$70.87	$414.87	1.7079	$242.91
Anthem Bronze Pathway POS 5000/40%	17575IN0780018	$601.89	0.5445	1.0238	1.0000	1.0015	$69.24	$405.28	1.7079	$237.30
Anthem Bronze Pathway POS 5000/40%	17575IN0780019	$601.89	0.5445	1.0515	1.0000	1.0015	$71.10	$416.24	1.7079	$243.71
Anthem Bronze Pathway POS 5000/40%	17575IN0780020	$601.89	0.5445	0.9907	1.0000	1.0015	$67.00	$392.19	1.7079	$229.63
Anthem Bronze Pathway POS 5000/40%	17575IN0780021	$601.89	0.5445	1.0609	1.0000	1.0015	$71.74	$419.95	1.7079	$245.89
Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan	17575IN0930005	$601.89	0.7038	0.9797	1.0000	1.0015	$85.67	$501.34	1.7079	$293.54
Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan	17575IN0930006	$601.89	0.8206	0.9797	1.0000	1.0015	$99.91	$584.56	1.7079	$342.27

Notes:

{1} This adjustment assumes a healthier than average population will select the catastrophic plan. The catastrophic adjustment factor is normalized to 1.0 across all plans for revenue neutrality across the entire block.

{2} The Plan Adjusted Index Rate is calculated by multiplying the Market Adjusted Index Rate by the AV and cost sharing, provider network, benefits in addition to the EHBs, and catastrophic plan adjustments and then adding the administrative costs. The Plan Adjusted Index Rate can also be described as a Plan Level Required Premium.

{3} See Exhibit H - Calibration.

{4} The Consumer Adjusted Premium Rate is calculated by dividing the Plan Adjusted Index Rate by the Calibration Factor. The Consumer Adjusted Premium Rate can also be described as a Plan Level Base Rate.

Exhibit P - Membership Projections for Cost-Sharing Reductions

Anthem Insurance Companies, Inc.
Individual

Rates Effective January 1, 2015

Silver Plan	Projected Membership by Subsidy Level:			
HIOS Standard Component Plan ID	100-150%	150%-200%	200%-250%	Standard
17575IN0700026	3,667	2,657	1,370	5,153
17575IN0700028	3,667	2,657	1,370	5,153
17575IN0700027	3,667	2,657	1,370	5,153
17575IN0770022	0	0	0	540
17575IN0770105	0	0	0	420
17575IN0770106	0	0	0	120
17575IN0770107	0	0	0	125
17575IN0770108	0	0	0	62
17575IN0770109	0	0	0	121
17575IN0770110	0	0	0	162
17575IN0770111	0	0	0	125
17575IN0770112	0	0	0	114
17575IN0770113	0	0	0	1,099
17575IN0770114	0	0	0	263
17575IN0770115	0	0	0	134
17575IN0770116	0	0	0	285
17575IN0770117	0	0	0	105
17575IN0770118	0	0	0	190
17575IN0770119	0	0	0	262
17575IN0770120	0	0	0	314
17575IN0770019	0	0	0	540
17575IN0770121	0	0	0	420
17575IN0770122	0	0	0	120
17575IN0770123	0	0	0	125
17575IN0770124	0	0	0	62
17575IN0770125	0	0	0	121
17575IN0770126	0	0	0	162
17575IN0770127	0	0	0	125
17575IN0770128	0	0	0	114
17575IN0770129	0	0	0	1,099
17575IN0770130	0	0	0	263
17575IN0770131	0	0	0	134
17575IN0770132	0	0	0	285
17575IN0770133	0	0	0	105
17575IN0770134	0	0	0	190
17575IN0770135	0	0	0	262
17575IN0770136	0	0	0	314
17575IN0770020	0	0	0	540
17575IN0770137	0	0	0	420
17575IN0770138	0	0	0	120
17575IN0770139	0	0	0	125
17575IN0770140	0	0	0	62
17575IN0770141	0	0	0	121
17575IN0770142	0	0	0	162
17575IN0770143	0	0	0	125
17575IN0770144	0	0	0	114
17575IN0770145	0	0	0	1,099
17575IN0770146	0	0	0	263
17575IN0770147	0	0	0	134
17575IN0770148	0	0	0	285
17575IN0770149	0	0	0	105
17575IN0770150	0	0	0	190
17575IN0770151	0	0	0	262
17575IN0770152	0	0	0	314
17575IN0770021	0	0	0	540
17575IN0770153	0	0	0	420
17575IN0770154	0	0	0	120
17575IN0770155	0	0	0	125
17575IN0770156	0	0	0	62
17575IN0770157	0	0	0	121
17575IN0770158	0	0	0	162
17575IN0770159	0	0	0	125
17575IN0770160	0	0	0	114
17575IN0770161	0	0	0	1,099
17575IN0770162	0	0	0	263
17575IN0770163	0	0	0	134
17575IN0770164	0	0	0	285
17575IN0770165	0	0	0	105
17575IN0770166	0	0	0	190
17575IN0770167	0	0	0	262
17575IN0770168	0	0	0	314
17575IN0930005	3,667	2,657	1,370	5,153

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

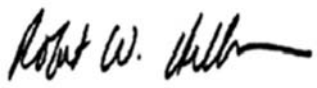
Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.



President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,660]	$[0 - 13,200]

****

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

****

The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits		
Primary Care Physician (PCP)	$[0 - 50]	[0 - 30]%
Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits.		
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		
**********		
Doctor visits		
Primary Care Physician (PCP)	$[0 - 50]	[0 - 30]%
Copayment applies to PCP office visit charge only.		
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		
**********		
Doctor visits		
Primary Care Physician (PCP)	$[0 - 50]	[0 - 30]%
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		

	Network	
	Copayment	**Coinsurance**
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 30]%
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited	$[0]	[0 - 30]% after Calendar Year

Prescription Drugs	Copayment	Coinsurance
to those Drugs listed on our Prescription Drug List (formulary).		Deductible
Mail Order Tier 1 (90-day supply) Tier 2 (90-day supply) Tier 3 (90-day supply) Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	 $[0 - 50] $[0 - 137.50] $[0] $[0]	 % [after Calendar Year Deductible] [0 - 30]% [after Calendar Year Deductible] [0 - 30]% after Calendar Year Deductible [0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
**********		
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty	

	Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible ~~and Out-of-Pocket Limit~~.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance

Routine Eye Exam	$[0]
[One per Calendar Year]	
Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

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Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- ~~For Members age 16 through 18;~~
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- ~~For Members age 16 through 18;~~
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a

benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.

- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). ~~However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain~~

~~Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card.~~

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
    1) Replace all or part of a missing body part and its adjoining tissues; or
    2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

    1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
    2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
    3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
    4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
    5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
    6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
    7) Cochlear implants.
    8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
    9) Restoration prosthesis (composite facial prosthesis).
    10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

    1) Dentures, replacing teeth or structures directly supporting teeth;
    2) Dental appliances;
    3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
    4) Artificial heart implants;
    5) Wigs (except as described above following cancer treatment.)

6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and

2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on

the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an ~~in~~In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an ~~in~~In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an ~~in~~In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the ~~in~~In-Network Transplant Provider agreement. Contact the Case Manager for specific ~~in~~In-Network Transplant Provider information for services received at or coordinated by an ~~in~~In-Network Transplant Provider Facility. Services received from an ~~out~~Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an ~~in~~In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, ~~in~~In-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Helpful tip: Receiving transplant evaluation and work-up services at an ~~in~~In-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source

for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or
    - Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and

vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss

programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the

Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.
- Compound Drugs

- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.

- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.

- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution
- Be capable of indicating intent
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution
- Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
- Not be emancipated
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

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How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding "Claim Forms" and "Notice of Claim" do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional ~~Coinsurance~~Cost-Sharing will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional ~~Coinsurance~~Cost-Sharing will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a

claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an Network Provider	**Services given by a BlueCard/Non-Network/ Non-Participating Provider**
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

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Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:

- an adverse utilization review determination; or
- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

An expedited request for external review from the U.S. Office of Personnel Management may be made at the same time as your request for an expedited appeal. See the 'Independent external review appeals' section for further information.

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or
    - a determination that a proposed service is Experimental/Investigational; or
2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one year after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If you do not agree with Our decision, you are entitled to request an independent, external review within one year of Our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714

with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. ~~Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your provider; you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim.~~Generally, an urgent situation is one that concerns an admission, availability of care, continued stay, or health care service for which you have received emergency services, but have not been discharged. A situation is also urgent if the standard External Review time frame would seriously jeopardize your life, health, or ability to regain maximum function. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review Our decision. If your claim was denied as not Medically Necessary or Experimental/Investigative, OPM will seek the binding opinion of an independent review organization (IRO). The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn Our decision, We will provide coverage or payment for your health care item or service and We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714 at any time. Additionally, the State of Indiana Department of Insurance may be able to help you file your appeal. Contact the Consumer Services Division of the Department of Insurance at (800) 622-4461 or (317) 232-2395, write to them at State of Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204 or electronically at www.ingov/idoi.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. ~~We~~ In general, OPM will accept External Grievance requests filed within ~~120 days~~one year after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain

any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums

have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan’s Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting Anthem to

use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. ~~The Copayment does not apply to any Deductible.~~

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant –** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any ��Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/29/2014		Supporting Document	Red-line version comparing HMO ON HIX 2015 original contract to Final HMO ON HIX 2015 contract_7-29-14	07/29/2014	Red-line version of FINAL 2015 ON HIX Exchange_7-29-14.pdf (Superceded)
07/02/2014		Form	Indiana Individual HMO On Exchange Contract	07/29/2014	IN_ONHIX_HMHS(1-15).pdf (Superceded)
05/27/2014		Form	Indiana Individual HMO Off Exchange Contract	07/02/2014	IN_OFFHIX_HMHS(1-15).pdf (Superceded)
05/27/2014		Form	Indiana Individual POS Off Exchange Contract	07/02/2014	IN_OFFHIX_PS(1-15).pdf (Superceded)
05/27/2014		Supporting Document	Statement of Variability	06/03/2014	SOV_HMO and POS ON and OFF HIX_2015.pdf (Superceded)
05/27/2014		Form	Indiana Individual HMO On Exchange Contract	07/02/2014	IN_ONHIX_HMHS(1-15).pdf (Superceded)
05/27/2014		Form	Indiana Individual HMO Off Exchange Contract	05/27/2014	IN_OFFHIX_HMHS(1-15).pdf (Superceded)
05/27/2014		Form	Indiana Individual POS On Exchange Contract	07/02/2014	IN_ONHIX_PS(1-15).pdf (Superceded)
05/27/2014		Form	Indiana Individual POS Off Exchange Contract	05/27/2014	IN_OFFHIX_PS(1-15).pdf (Superceded)
05/09/2014		Supporting Document	Statement of Variability	05/27/2014	SOV_HMO and POS ON and OFF HIX_2015.pdf (Superceded)
05/09/2014		Supporting Document	Red-lined versions of the IN HMO On Exchange contract from 2014 to 2015 (Parts 1 and 2)	05/23/2014	PART 1 - Red-lined version of IN HMO_ON HIX contract from 2014 to 2015.pdf (Superceded) PART 2 - Red-lined version of IN HMO_ON HIX contract from 2014 to 2015.pdf (Superceded)
05/08/2014		Form	Indiana Individual POS Off Exchange Contract	05/27/2014	IN_OFFHIX_PS(1-15).pdf (Superceded)
05/08/2014		Form	Indiana Individual POS On Exchange Contract	05/27/2014	IN_ONHIX_PS(1-15).pdf
05/08/2014		Form	Indiana Individual HMO On Exchange Contract	05/27/2014	IN_ONHIX_HMHS(1-15).pdf (Superceded)

SERFF Tracking #:	*AWLP-129529773*	***State Tracking #:***	*IN_ONHIX_HMHS(1/15)*	***Company Tracking #:***	

State:	*Indiana*	***Filing Company:***	*Anthem Insurance Companies, Inc.*
TOI/Sub-TOI:	*H16I Individual Health - Major Medical/H16I.005B Individual - Point-of-Service (POS)*		
Product Name:	*IN 2015 - On- and Off-Exchange - IND*		
Project Name/Number:	*/*		

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/08/2014		Form	Indiana Individual HMO Off Exchange Contract	05/27/2014	IN_OFFHIX_HMHS(1-15).pdf (Superceded)

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

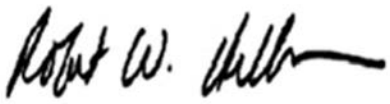
Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.



President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,660]	$[0 - 13,200]

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If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

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The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits		
Primary Care Physician (PCP)	$[0 - 50]	[0 - 30]%
Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits.		
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		
**********		
Doctor visits		
Primary Care Physician (PCP)	$[0 - 50]	[0 - 30]%
Copayment applies to PCP office visit charge only.		
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		
**********		
Doctor visits		
Primary Care Physician (PCP)	$[0 - 50]	[0 - 30]%
Specialty Care Physician (SCP)	$[0]	[0 - 30]%
Other Office Services	$[0]	[0 - 30]%
[Optional Language] **********		

	Network	
	Copayment	**Coinsurance**
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 30]%
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited	$[0]	[0 - 30]% after Calendar Year

Prescription Drugs	**Copayment**	**Coinsurance**
to those Drugs listed on our Prescription Drug List (formulary).		Deductible
Mail Order Tier 1 (90-day supply) Tier 2 (90-day supply) Tier 3 (90-day supply) Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	 $[0 - 50] $[0 - 137.50] $[0] $[0]	 % [after Calendar Year Deductible] [0 - 30]% [after Calendar Year Deductible] [0 - 30]% after Calendar Year Deductible [0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
**********		
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty	

	Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance

Routine Eye Exam	$[0]
[One per Calendar Year]	
Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

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Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a

benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.

- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician's office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:
  1) Allergy serum extracts;
  2) Chem strips, Glucometer, and lancets;
  3) Clinitest;

4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:

1) Replace all or part of a missing body part and its adjoining tissues; or
2) Replace all or part of the function of a permanently useless or malfunctioning body part.

Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

Covered Services may include, but are not limited to:

1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
7) Cochlear implants.
8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
9) Restoration prosthesis (composite facial prosthesis).
10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

Non-covered Prosthetic appliances include but are not limited to:

1) Dentures, replacing teeth or structures directly supporting teeth;
2) Dental appliances;
3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
  2) not solely for comfort or convenience.

  Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is

provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;

- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control.

Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

> **Helpful tip**: When Prescription Drugs are covered under this benefit, they will not also be covered under the “Where You Can Obtain Prescription Drugs” benefit. Also, if Prescription Drugs are covered under the “Where You Can Obtain Prescription Drugs” benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;
    - Type 2 Diabetes Mellitus;
    - Cholesterol;
    - Child or Adult obesity.
2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.

- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT

an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent.
- Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source

for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or
    - Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and

vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss

programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the

Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.
- Compound Drugs

- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.

- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.
- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.

- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

    For a Qualified Individual age 21 and over, the applicant must:

    - Not be living in an institution
    - Be capable of indicating intent
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

    For a Qualified Individual under age 21, the applicant must:

    - Not be living in an institution
    - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
    - Not be emancipated
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Cost-Sharing will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Cost-Sharing will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a

claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review (“requesting Provider”). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services given by an Network Provider	**Services given by a BlueCard/Non-Network/ Non-Participating Provider**
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment, seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

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Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or

- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

An expedited request for external review from the U.S. Office of Personnel Management may be made at the same time as your request for an expedited appeal. See the 'Independent external review appeals' section for further information.

External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or
    - a determination that a proposed service is Experimental/Investigational; or
2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one year after you are notified of the Appeal panel’s decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If you do not agree with Our decision, you are entitled to request an independent, external review within one year of Our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714 with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one that concerns an admission, availability of care, continued stay, or health care service for which you have received emergency services, but have not been discharged. A situation is also urgent if the standard External Review time frame would seriously jeopardize your life, health, or ability to regain maximum function. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review Our decision. If your claim was denied as not Medically Necessary or Experimental/Investigative, OPM will seek the binding opinion of an independent review organization (IRO). The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn Our decision, We will provide coverage or payment for your health care item or service and We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714 at any time. Additionally, the State of Indiana Department of Insurance may be able to help you file your appeal. Contact the Consumer Services Division of the Department of Insurance at (800) 622-4461 or (317) 232-2395, write to them at State of Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204 or electronically at www.ingov/idoi.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. In general, OPM will accept External Grievance requests filed within one year after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        — The Plan covering the Custodial parent;
        — The Plan covering the spouse of the Custodial parent;
        — The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain

any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums

have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan’s Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting Anthem to

use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant –** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any ��Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,660]	$[0 - 13,200]

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If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

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The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	Copayment	Coinsurance
Tier 1 (90-day supply)	$[0 - 50]	% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
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Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

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Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a

benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.

- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain

Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;
  3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
  4) Artificial heart implants;
  5) Wigs (except as described above following cancer treatment.)

6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and

2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on

the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an In-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an In-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the In-Network Transplant Provider agreement. Contact the Case Manager for specific In-Network Transplant Provider information for services received at or coordinated by an In-Network Transplant Provider Facility. Services received from an Out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an In-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, In-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an In-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers.

    Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

    For a Qualified Individual age 21 and over, the applicant must:

    - Not be living in an institution
    - Be capable of indicating intent
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

    For a Qualified Individual under age 21, the applicant must:

    - Not be living in an institution
    - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
    - Not be emancipated
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

Each family Member's Maximum Allowed Amount for Covered Services is applied to his/her individual Deductible. Once two or more family Members' Maximum Allowed Amount for Covered Services combine to equal the family Deductible, then no other Individual Deductible needs to be met for that calendar year. No one person can contribute more than his/her Individual Deductible to the Family Deductible.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Cost-Sharing will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Cost-Sharing will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a

claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or
    - a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one year after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If you do not agree with Our decision, you are entitled to request an independent, external review within one year of Our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714 with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your provider; you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review Our decision. If your claim was denied as not Medically Necessary or Experimental/Investigative, OPM will seek the binding opinion of an independent review organization (IRO). The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify

for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn Our decision, We will provide coverage or payment for your health care item or service and We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714 at any time. Additionally, the State of Indiana Department of Insurance may be able to help you file your appeal. Contact the Consumer Services Division of the Department of Insurance at (800) 622-4461 or (317) 232-2395, write to them at State of Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204 or electronically at www.ingov/idoi.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant –** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,600]	$[0 - 13,200]

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If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

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The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	**Copayment**	**Coinsurance**
Tier 1 (90-day supply)	$[0 - 50]	[0 - 30]% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
**********		
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a

benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.

- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain

Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;
  3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
  4) Artificial heart implants;
  5) Wigs (except as described above following cancer treatment.)

6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and

2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on

the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers.

    Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond the Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications or other forms or statements the Plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

This section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting care in the right setting and how it affects preauthorization” paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription

Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs -- The term Generic Drugs means a Prescription Drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider -- A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);

    - Surgery;

    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:

- Is licensed as such, where required;
- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant -** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  - Provides skilled nursing and other services on a visiting basis in the Member's home; and

  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  - Skilled nursing services

  - Prescription Drugs

  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;

  2. rest care;

  3. extended care;

4. convalescent care;
5. care of the aged;
6. Custodial Care;
7. educational care;
8. treatment of Mental Health Disorders;
9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.
- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.
- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how

you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Network Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

	Network		**Non-Network**	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Calendar year deductible	$[0 - 5,000]	$[0 - 10,000]	$[0 - 15,000]	$[0 - 30,000]
The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]	$[0 - 30,000]	$[0 - 60,000]

	Network		**Non-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services	$[0]	[0 - 40]%	$[0]	[0 - 40]%
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.			
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.			
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0-3] visits; care is then subject to Deductible and Coinsurance for subsequent	$[0 - 50]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
visits.				
Specialty Care Provider (SCP)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Other Office Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Emergency room visits (Copayment waived if admitted)	$[0 - 200]	[0 - 40]%	$[0 - 200]	[0 - 40]%
Urgent Care Center	$[0 - 50]	[0 - 40]%	$[0 - 50]	[0 - 40]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year, Network and Non-Network combined, and a maximum of [164] visits per Member, per lifetime Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospice Care	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospital Services				
Inpatient	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Maximum limit of [60] days per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Mental Health & Substance Abuse				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Outpatient facility	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient office visit	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Diagnostic tests				
Laboratory	$[0]	[0 - 40]%	$[0]	[0 - 60]%
MRI, CT, & PET scan	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Radiology	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Speech, Occupational, and Manipulation Therapy** Limited to a maximum of [20] visits per Member, per Calendar Year for physical therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for occupational therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for speech therapy, Network and Non-Network combined. Limited to a maximum of [12] visits per Member, per Calendar Year for manipulation therapy, Network and Non-Network combined. **Cardiac Rehabilitation** Limited to a maximum of [36] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home	$[0]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.				
Preventive Care Services Network Care not subject to Deductible	$0	0%	$[0]	[0 - 60]%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Surgery				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient treatment	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Ambulatory Surgical Center	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.		Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]% Covered transplant procedure charges at a Non-Network Transplant Provider Facility will NOT apply to

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
				your Out-of-Pocket Maximum.
Prescription Drugs	**Participating Pharmacy**		**Non-Participating Pharmacy**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Retail (30-day supply)				
Tier 1	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 2	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Mail Order				
Tier 1 (90-day supply)	$[0]	[0 - 40]% [after Calendar Year Deductible]	Not Covered	
Tier 2 (90-day supply)	$[0]	[0 - 40] % [after Calendar Year Deductible]	Not Covered	
Tier 3	$[0]	[0 - 40]% after Calendar Year	Not Covered	

Prescription Drugs	Participating Pharmacy		Non-Participating Pharmacy	
	Copayment	Coinsurance	Copayment	Coinsurance
(90-day supply) Tier 4 (30-day supply)	$[0]	Deductible [0 - 40]% after Calendar Year Deductible	Not Covered	
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, Participating Specialty Pharmacy, or Non-Participating Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.			

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance	Pediatric Non-Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%	[0 - 10]%
Basic Restorative Services	[0 - 40]%	[0 - 40]%
Oral Surgery Services	[0 - 50]%	[0 - 50]%
Endodontic Services	[0 - 50]%	[0 - 50]%
Periodontal Services	[0 - 50]%	[0 - 50]%
Major Restorative Services	[0 - 50]%	[0 - 50]%
Prosthodontic Services	[0 - 50]%	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period.	[0 - 50]%	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

	Network Copayment	Non-Network Payment Allowance
Routine Eye Exam	$[0]	$[30]
[One per Calendar Year]		
Standard Plastic Lenses*		
[One per Calendar Year]		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]
Progressive	$[0]	$[40]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.		
Frames* (formulary) This Plan offers a selection of covered frames.	$[0]	$[45]
[One per Calendar Year]		
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	$[Covered in Full]	$[210]
[One per Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the Plan will pay for the services.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Contract. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a) The National Institutes of Health.
    b) The Centers for Disease Control and Prevention.
    c) The Agency for Health Care Research and Quality.
    d) The Centers for Medicare & Medicaid Services.
    e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.

- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be

considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Mail Order

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on

the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables, including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for services rendered by Providers located outside the state of Indiana unless the services are for Emergency care, urgent care and ambulance services; or the services are approved in advance by Anthem.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related

means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the “Covered Services” section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage’s benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond the Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications or other forms or statements the Plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

This section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

Unless prohibited by law, the Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers located in the state of Indiana; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits**.

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has

agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include but are not limited to:

- amounts over the Maximum Allowed Amount;
- amounts over any Contract maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Network Out-of-Pocket Limit is satisfied, no additional Network Coinsurance will be required for the remainder of the calendar year.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Coinsurance will be required for the remainder of the calendar year, except for out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Participating or Non-Participating Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or Cost-Share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances, you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating Cost-Share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize you to go to an available Non-Participating Provider for that Covered Service and We agree that the network Cost-Share will apply.

Your Plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost-Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, you may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Contract. You must exhaust the Plan's appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Anthem covers only limited healthcare services received outside of Our Service Area. For example, Emergency or Urgent Care obtained out of Our Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment or Coinsurance stated in this Contract.

Whenever you obtain covered services or supplies outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for Emergency or Urgent Care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Our Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, we may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by a Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription

Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs -- The term Generic Drugs means a Prescription Drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider -- A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:

- Is licensed as such, where required;
- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
  1. constituted, licensed, and operated as set forth in the laws that apply;
  2. equipped to provide low-risk maternity care;
  3. adequately staffed with qualified personnel who:
     a. provide care at childbirth;
     b. are practicing within the scope of their training and experience; and
     c. are licensed if required; and
  4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant -** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  - Provides skilled nursing and other services on a visiting basis in the Member's home; and

  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  - Skilled nursing services

  - Prescription Drugs

  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;

  2. rest care;

  3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how

you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

STATEMENT OF VARIABILITY
INDIVIDUAL HMO/HSA and POS – On and OFF Exchange Products
For Contract Forms:
IN_ONHIX_HMHS(1/15)
IN_ONHIX_PS(1/15)
IN_OFFHIX_HMHS(1/15)
IN_OFFHIX_PS(1/15)

General Variable Information

Most numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Definitions may vary to the extent that such definitions may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Website URL addresses (e.g. [www.anthem.com]) are bracketed throughout the Contract for removal if necessary or to update if the web addresses changes.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval.

Please note that the deductible, out of pocket and cost shares value ranges bracketed in the schedule will only be arranged to match our company's individual benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

The following is an explanation of the variables used within this Contract form:

FRONT COVER:

Product Names is bracketed to allow for different names to appear depending on a member's benefit selection. The product names that will populate this area are:

	Catastrophic	HMO	Anthem Catastrophic Pathway X $6600/0%
	Catastrophic	HMO	Anthem Catastrophic Pathway $6600/0%
	Bronze - HSA	HMO	Anthem Bronze Pathway X 0% for HSA
	Bronze	HMO	Anthem Bronze Pathway X 6250/30%
	Bronze	HMO	Anthem Bronze Pathway X 5750/20%

	Bronze	POS	Anthem Bronze Pathway X POS 5000/40%
	Bronze - HSA	HMO	Anthem Bronze Pathway X 20% for HSA
	Bronze	HMO	Anthem Bronze Pathway X 4300/20%
	Silver	HMO	Anthem Silver Pathway X 3500/0%
	Silver	HMO	Anthem Silver Pathway X 3500/0% S04
	Silver	HMO	Anthem Silver Pathway X 3500/0% S05
	Silver	HMO	Anthem Silver Pathway X 3500/0% S06
	Silver - HSA	HMO	Anthem Silver Pathway X 10% for HSA
	Silver - HSA	HMO	Anthem Silver Pathway X 10% for HSA S04
	Silver	HMO	Anthem Silver Pathway X 10% S05
	Silver	HMO	Anthem Silver Pathway X 10% S06
	Silver	HMO	Anthem Silver Pathway X 2500/10%
	Silver	HMO	Anthem Silver Pathway X 2500/10% S04
	Silver	HMO	Anthem Silver Pathway X 250010% S05
	Silver	HMO	Anthem Silver Pathway X 2500/10% S06
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S04
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S05
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S06
	Gold	HMO	Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan
	Bronze	HMO	Anthem Bronze Pathway 5750/20%
	Bronze	HMO	Anthem Bronze Pathway 6000/30%
	Bronze	POS	Anthem Bronze Pathway POS 5000/40%
	Bronze - HSA	HMO	Anthem Bronze Pathway 0% for HSA
	Bronze - HSA	HMO	Anthem Bronze Pathway 20% for HSA
	Silver	HMO	Anthem Silver Pathway 2850/15%
	Silver	HMO	Anthem Silver Pathway 2500/10%
	Silver - HSA	HMO	Anthem Silver Pathway 10% for HSA
	Silver	HMO	Anthem Silver Pathway 1750/20%
	Gold	HMO	Anthem Gold Pathway 1250/10%
	Bronze	HMO	Anthem Bronze Pathway X 0% AI
	Bronze	HMO	Anthem Bronze Pathway X 6250/30% AI
	Bronze	HMO	Anthem Bronze Pathway X 0/0% AI
	Bronze	POS	Anthem Bronze Pathway X POS 5000/40% AI
	Bronze	HMO	Anthem Bronze Pathway X 20% AI
	Bronze	HMO	Anthem Bronze Pathway X 4300/20% AI

	Silver	HMO	Anthem Silver Pathway X 3500/0% AI
	Silver	HMO	Anthem Silver Pathway X 10% AI
	Silver	HMO	Anthem Silver Pathway X 2500/10% AI
	Silver	HMO	Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan AI
	Gold	HMO	Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan AI

Anthem Logo and Company address is bracketed to allow for future change.

SCHEDULE OF BENEFITS:

Deductible amount option ranges are as shown in the schedule, for the different metal option offerings.

HMO/HSA ONLY – HSA specific deductible language is shown within asterisks as optional language that will only pull into HSA products chosen by the member.

Out of Pocket Limit (The most you will pay per calendar year) ranges (individual and family) are as shown in the schedule for the different metal option offerings.

Copayment amount ranges are as shown in the schedule for the different metal option offerings.

Coinsurance/Cost Share options ranges are as shown in schedule for the different metal option offerings.

Visit limits and **Day limit** ranges are as shown in the schedule for the different metal option offerings.

Ambulance – Cost share options ranges are as shown in the schedule.

Doctor visits - Cost share options ranges are as shown in the schedule. 3 different options for this benefit are available and are notated with the asterisk as optional. Only one option will appear in a member's contract based on the product selected.

Durable Medical Equipment - Cost share options ranges are as shown in the schedule.

Emergency room - Cost share options ranges are as shown in the schedule.

Urgent Care Center - Cost share options ranges are as shown in the schedule.

Home Health Care - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Private Duty Nursing - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Hospice Care - Cost share options ranges are as shown in the schedule.

Hospital Services - Cost share options ranges are as shown in the schedule.

Inpatient PM&R - Cost share options ranges are as shown in the schedule. The day limits range is as shown in the schedule for this benefit.

Mental Health/Substance Abuse – Cost share options ranges are as shown in the schedule.

Outpatient Diagnostic tests - Cost share options ranges are as shown in the schedule.

Outpatient Therapy Services - Cost share options ranges are as shown in the schedule. The visit limits range for each of the Therapy Services is as shown in the schedule for these benefits.

Prosthetics - Cost share options ranges are as shown in the schedule.

Skilled Nursing Care - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Surgery - Cost share options ranges are as shown in the schedule.

Transplant HOTT - Cost share options ranges are as shown in the schedule. The dollar limits for the transplant transportation, lodging and unrelated donor search is as shown in the schedule for this benefit.

Prescription Drugs - Cost share options ranges are as shown in the schedule.

Pediatric Dental Services - Cost share options ranges are as shown in the schedule.

Pediatric Vision Services - Cost share options ranges are as shown in the schedule.

Eligible American Indiana statement – This statement will appear in all ON Exchange products as selected.

COVERED SERVICES:

Phone numbers and addresses – bracketed throughout the Covered Services section to allow us to update those if changes are necessary.

CLAIMS PAYMENT:

Deductible Calculation/Out-of-Pocket Limit Calculation –
HMO contract only: Two versions of language are provided within brackets for flexibility. One version for HMO, and one version for HMO/HSA. Only one version of language will appear in a member's contract, depending upon which product they select.

MEMBER GRIEVANCES:

HMO ON HIX contract only –
External Grievance – There are two versions of the External Grievance provision, indicated as optional language within asterisks. The first version is the IN State required provision for the HMO/HSA On Exchange product offering. The second version is the OPM required provision for the MSP On Exchange product offering. Only one version of this language will pull into a member's contract, depending on which product they select. At no time will the language in either version change without first being filed and approved by your department.

Changes in Premium – This provision is bracketed for flexibility, however, it will always appear as shown in a member's contract for ON EXCHANGE. If this value changes, we will file the new value with your department for approval.

Value-Added and Incentive Programs - This provision is bracketed for flexibility. Anthem is currently in discussions with a large corporation regarding an arrangement to offer an Exchange product that could be accompanied by incentives and value-added programs that will be provided by that corporation or its vendors and partners. The bracketed provision will appear as shown in the member's contract, or not appear at all, once a decision regarding this program is finalized.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,660]	$[0 - 13,200]

****

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

****

The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	**Copayment**	**Coinsurance**
Tier 1 (90-day supply)	$[0 - 50]	% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
**********		
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

****

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a

benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.

- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain

Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;
  3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
  4) Artificial heart implants;
  5) Wigs (except as described above following cancer treatment.)

6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and

2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers.

    Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

    For a Qualified Individual age 21 and over, the applicant must:

    - Not be living in an institution
    - Be capable of indicating intent
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

    For a Qualified Individual under age 21, the applicant must:

    - Not be living in an institution
    - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
    - Not be emancipated
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting care in the right setting and how it affects preauthorization” paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or
    - a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one year after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If you do not agree with Our decision, you are entitled to request an independent, external review within one year of Our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714 with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your provider; you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review Our decision. If your claim was denied as not Medically Necessary or Experimental/Investigative, OPM will seek the binding opinion of an independent review organization (IRO). The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify

for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn Our decision, We will provide coverage or payment for your health care item or service and We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714 at any time. Additionally, the State of Indiana Department of Insurance may be able to help you file your appeal. Contact the Consumer Services Division of the Department of Insurance at (800) 622-4461 or (317) 232-2395, write to them at State of Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204 or electronically at www.ingov/idoi.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant –** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,600]	$[0 - 13,200]

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If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

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The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	**Copayment**	**Coinsurance**
Tier 1 (90-day supply)	$[0 - 50]	[0 - 30]% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
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Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a

benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.

- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.

- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain

Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office. Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

  Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;
  3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
  4) Artificial heart implants;
  5) Wigs (except as described above following cancer treatment.)

6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

  1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and

2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers.

    Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond the Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications or other forms or statements the Plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

This section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting care in the right setting and how it affects preauthorization” paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription

Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs -- The term Generic Drugs means a Prescription Drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider -- A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);

    - Surgery;

    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:

- Is licensed as such, where required;
- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant -** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  - Provides skilled nursing and other services on a visiting basis in the Member's home; and

  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  - Skilled nursing services

  - Prescription Drugs

  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;

  2. rest care;

  3. extended care;

4. convalescent care;
5. care of the aged;
6. Custodial Care;
7. educational care;
8. treatment of Mental Health Disorders;
9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.
- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.
- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how

you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Network Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

	Network		**Non-Network**	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Calendar year deductible	$[0 - 5,000]	$[0 - 10,000]	$[0 - 15,000]	$[0 - 30,000]
The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]	$[0 - 30,000]	$[0 - 60,000]

	Network		**Non-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services	$[0]	[0 - 40]%	$[0]	[0 - 40]%
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.			
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.			
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0-3] visits; care is then subject to Deductible and Coinsurance for subsequent	$[0 - 50]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
visits.				
Specialty Care Provider (SCP)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Other Office Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Emergency room visits (Copayment waived if admitted)	$[0 - 200]	[0 - 40]%	$[0 - 200]	[0 - 40]%
Urgent Care Center	$[0 - 50]	[0 - 40]%	$[0 - 50]	[0 - 40]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year, Network and Non-Network combined, and a maximum of [164] visits per Member, per lifetime Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospice Care	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospital Services				
Inpatient	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Maximum limit of [60] days per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Mental Health & Substance Abuse				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Outpatient facility	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient office visit	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Diagnostic tests				
Laboratory	$[0]	[0 - 40]%	$[0]	[0 - 60]%
MRI, CT, & PET scan	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Radiology	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Speech, Occupational, and Manipulation Therapy** Limited to a maximum of [20] visits per Member, per Calendar Year for physical therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for occupational therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for speech therapy, Network and Non-Network combined. Limited to a maximum of [12] visits per Member, per Calendar Year for manipulation therapy, Network and Non-Network combined. **Cardiac Rehabilitation** Limited to a maximum of [36] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home	$[0]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.				
Preventive Care Services Network Care not subject to Deductible	$0	0%	$[0]	[0 - 60]%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Surgery				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient treatment	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Ambulatory Surgical Center	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.		Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]% Covered transplant procedure charges at a Non-Network Transplant Provider Facility will NOT apply to

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
				your Out-of-Pocket Maximum.
Prescription Drugs	**Participating Pharmacy**		**Non-Participating Pharmacy**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Retail (30-day supply)				
Tier 1	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 2	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Tier 4	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).				
Mail Order				
Tier 1 (90-day supply)	$[0]	[0 - 40]% [after Calendar Year Deductible]	Not Covered	
Tier 2 (90-day supply)	$[0]	[0 - 40] % [after Calendar Year Deductible]	Not Covered	
Tier 3	$[0]	[0 - 40]% after Calendar Year	Not Covered	

Prescription Drugs	Participating Pharmacy		Non-Participating Pharmacy	
	Copayment	Coinsurance	Copayment	Coinsurance
(90-day supply) Tier 4 (30-day supply)	$[0]	Deductible [0 - 40]% after Calendar Year Deductible	Not Covered	
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, Participating Specialty Pharmacy, or Non-Participating Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.			

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance	Pediatric Non-Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%	[0 - 10]%
Basic Restorative Services	[0 - 40]%	[0 - 40]%
Oral Surgery Services	[0 - 50]%	[0 - 50]%
Endodontic Services	[0 - 50]%	[0 - 50]%
Periodontal Services	[0 - 50]%	[0 - 50]%
Major Restorative Services	[0 - 50]%	[0 - 50]%
Prosthodontic Services	[0 - 50]%	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period.	[0 - 50]%	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

	Network Copayment	Non-Network Payment Allowance
Routine Eye Exam	$[0]	$[30]
[One per Calendar Year]		
Standard Plastic Lenses*		
[One per Calendar Year]		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]
Progressive	$[0]	$[40]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.		
Frames* (formulary) This Plan offers a selection of covered frames.	$[0]	$[45]
[One per Calendar Year]		
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	$[Covered in Full]	$[210]
[One per Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the Plan will pay for the services.

****

Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no

Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Contract. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a) The National Institutes of Health.
    b) The Centers for Disease Control and Prevention.
    c) The Agency for Health Care Research and Quality.
    d) The Centers for Medicare & Medicaid Services.
    e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum

Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).

- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for services rendered by Providers located outside the state of Indiana unless the services are for Emergency care, urgent care and ambulance services; or the services are approved in advance by Anthem.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related

means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

    For a Qualified Individual age 21 and over, the applicant must:

    - Not be living in an institution
    - Be capable of indicating intent
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

    For a Qualified Individual under age 21, the applicant must:

    - Not be living in an institution
    - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
    - Not be emancipated
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers located in the state of Indiana; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits**.

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has

agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include but are not limited to:

- amounts over the Maximum Allowed Amount;
- amounts over any Contract maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Network Out-of-Pocket Limit is satisfied, no additional Network Coinsurance will be required for the remainder of the calendar year.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Coinsurance will be required for the remainder of the calendar year, except for out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Participating or Non-Participating Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or Cost-Share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances, you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating Cost-Share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize you to go to an available Non-Participating Provider for that Covered Service and We agree that the network Cost-Share will apply.

Your Plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost-Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, you may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Contract. You must exhaust the Plan’s appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Anthem covers only limited healthcare services received outside of Our Service Area. For example, Emergency or Urgent Care obtained out of Our Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee (“Host Blue”) with which Anthem has a relationship (referred to as an “Inter-Plan Program”), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment or Coinsurance stated in this Contract.

Whenever you obtain covered services or supplies outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for Emergency or Urgent Care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Our Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, we may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting care in the right setting” paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by a Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant –** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Network Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

	Network		**Non-Network**	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Calendar year deductible	$[0 - 5,000]	$[0 - 10,000]	$[0 - 15,000]	$[0 - 30,000]
The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]	$[0 - 30,000]	$[0 - 60,000]

	Network		**Non-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services	$[0]	[0 - 40]%	$[0]	[0 - 40]%
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.			
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.			
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0-3] visits; care is then subject to Deductible and Coinsurance for subsequent	$[0 - 50]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
visits.				
Specialty Care Provider (SCP)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Other Office Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Emergency room visits (Copayment waived if admitted)	$[0 - 200]	[0 - 40]%	$[0 - 200]	[0 - 40]%
Urgent Care Center	$[0 - 50]	[0 - 40]%	$[0 - 50]	[0 - 40]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year, Network and Non-Network combined, and a maximum of [164] visits per Member, per lifetime Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospice Care	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospital Services				
Inpatient	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Maximum limit of [60] days per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Mental Health & Substance Abuse				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Outpatient facility	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient office visit	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Diagnostic tests				
Laboratory	$[0]	[0 - 40]%	$[0]	[0 - 60]%
MRI, CT, & PET scan	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Radiology	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Speech, Occupational, and Manipulation Therapy** Limited to a maximum of [20] visits per Member, per Calendar Year for physical therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for occupational therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for speech therapy, Network and Non-Network combined. Limited to a maximum of [12] visits per Member, per Calendar Year for manipulation therapy, Network and Non-Network combined. **Cardiac Rehabilitation** Limited to a maximum of [36] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home	$[0]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.				
Preventive Care Services Network Care not subject to Deductible	$0	0%	$[0]	[0 - 60]%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Surgery				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient treatment	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Ambulatory Surgical Center	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.		Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]% Covered transplant procedure charges at a Non-Network Transplant Provider Facility will NOT apply to

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
				your Out-of-Pocket Maximum.
Prescription Drugs	**Participating Pharmacy**		**Non-Participating Pharmacy**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Retail (30-day supply)				
Tier 1	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 2	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Tier 4	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).				
Mail Order				
Tier 1 (90-day supply)	$[0]	[0 - 40]% [after Calendar Year Deductible]	Not Covered	
Tier 2 (90-day supply)	$[0]	[0 - 40] % [after Calendar Year Deductible]	Not Covered	
Tier 3	$[0]	[0 - 40]% after Calendar Year	Not Covered	

Prescription Drugs	Participating Pharmacy		Non-Participating Pharmacy	
	Copayment	Coinsurance	Copayment	Coinsurance
(90-day supply) Tier 4 (30-day supply)	$[0]	Deductible [0 - 40]% after Calendar Year Deductible	Not Covered	
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, Participating Specialty Pharmacy, or Non-Participating Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.			

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance	Pediatric Non-Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%	[0 - 10]%
Basic Restorative Services	[0 - 40]%	[0 - 40]%
Oral Surgery Services	[0 - 50]%	[0 - 50]%
Endodontic Services	[0 - 50]%	[0 - 50]%
Periodontal Services	[0 - 50]%	[0 - 50]%
Major Restorative Services	[0 - 50]%	[0 - 50]%
Prosthodontic Services	[0 - 50]%	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period.	[0 - 50]%	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

	Network Copayment	Non-Network Payment Allowance
Routine Eye Exam	$[0]	$[30]
[One per Calendar Year]		
Standard Plastic Lenses*		
[One per Calendar Year]		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]
Progressive	$[0]	$[40]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.		
Frames* (formulary) This Plan offers a selection of covered frames.	$[0]	$[45]
[One per Calendar Year]		
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	$[Covered in Full]	$[210]
[One per Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the Plan will pay for the services.

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Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no

Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Contract. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a) The National Institutes of Health.
    b) The Centers for Disease Control and Prevention.
    c) The Agency for Health Care Research and Quality.
    d) The Centers for Medicare & Medicaid Services.
    e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.

- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be

considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for services rendered by Providers located outside the state of Indiana unless the services are for Emergency care, urgent care and ambulance services; or the services are approved in advance by Anthem.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related

means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

    For a Qualified Individual age 21 and over, the applicant must:

    - Not be living in an institution
    - Be capable of indicating intent
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

    For a Qualified Individual under age 21, the applicant must:

    - Not be living in an institution
    - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
    - Not be emancipated
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers located in the state of Indiana; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits**.

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has

agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include but are not limited to:

- amounts over the Maximum Allowed Amount;
- amounts over any Contract maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Generally, Copayments are not subject to and do not apply to the Deductible, however to confirm how your Plan works, please refer to the Schedule of Cost-Shares and Benefits.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Network Out-of-Pocket Limit is satisfied, no additional Network Coinsurance will be required for the remainder of the calendar year.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Coinsurance will be required for the remainder of the calendar year, except for out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Participating or Non-Participating Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or Cost-Share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances, you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating Cost-Share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize you to go to an available Non-Participating Provider for that Covered Service and We agree that the network Cost-Share will apply.

Your Plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost-Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, you may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Contract. You must exhaust the Plan's appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Anthem covers only limited healthcare services received outside of Our Service Area. For example, Emergency or Urgent Care obtained out of Our Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment or Coinsurance stated in this Contract.

Whenever you obtain covered services or supplies outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for Emergency or Urgent Care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Our Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, we may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by a Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant –** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

STATEMENT OF VARIABILITY
INDIVIDUAL HMO/HSA and POS – On and OFF Exchange Products
For Contract Forms:
IN_ONHIX_HMHS(1/15)
IN_ONHIX_PS(1/15)
IN_OFFHIX_HMHS(1/15)
IN_OFFHIX_PS(1/15)

General Variable Information

Most numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law.

Paragraphs vary to the extent that such paragraphs may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Definitions may vary to the extent that such definitions may be included, omitted or transferred to another page to suit the needs of a particular group subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions.

Website URL addresses (e.g. [www.anthem.com]) are bracketed throughout the Contract for removal if necessary or to update if the web addresses changes.

We also reserve the right to amend the attached to fix any minor typographical errors we may have neglected to find prior to submitting for approval.

Please note that the deductible, out of pocket and cost shares value ranges bracketed in the schedule will only be arranged to match our company's individual benefit/metal plan offerings. At no time will this variable information be arranged in such a way as to violate the laws of the State of Indiana.

The following is an explanation of the variables used within this Contract form:

FRONT COVER:

Product Names is bracketed to allow for different names to appear depending on a member's benefit selection. The product names that will populate this area are:

Anthem Catastrophic Pathway X $6600/0%
Anthem Catastrophic Pathway $6600/0%
Anthem Bronze Pathway X 0% for HSA
Anthem Bronze Pathway X 6250/30%
Anthem Bronze Pathway X 5750/20%
Anthem Bronze Pathway X POS 5000/40%

Anthem Bronze Pathway X 20% for HSA
Anthem Bronze Pathway X 4300/20%
Anthem Silver Pathway X 3500/0%
Anthem Silver Pathway X 3000/0% S04
Anthem Silver Pathway X 800/0% S05
Anthem Silver Pathway X 150/0% S06
Anthem Silver Pathway X 10% for HSA
Anthem Silver Pathway X 10% for HSA S04
Anthem Silver Pathway X 0% S05
Anthem Silver Pathway X 0% S06
Anthem Silver Pathway X 2500/10%
Anthem Silver Pathway X 2450/10% S04
Anthem Silver Pathway X 750/10% S05
Anthem Silver Pathway X 200/10% S06
Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan
Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S04
Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S05
Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan S06
Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan
Anthem Bronze Pathway 5750/20%
Anthem Bronze Pathway 6000/30%
Anthem Bronze Pathway POS 5000/40%
Anthem Bronze Pathway 0% for HSA
Anthem Bronze Pathway 20% for HSA
Anthem Silver Pathway 2850/15%
Anthem Silver Pathway 2500/10%
Anthem Silver Pathway 10% for HSA
Anthem Silver Pathway 1750/20%
Anthem Gold Pathway 1250/10%
Anthem Bronze Pathway X 0/0% AI
Anthem Bronze Pathway X 0/0% AI
Anthem Bronze Pathway X 0/0% AI
Anthem Bronze Pathway X POS 0/0% AI
Anthem Bronze Pathway X 0/0% AI
Anthem Bronze Pathway X 0/0% AI
Anthem Silver Pathway X 0/0% AI
Anthem Silver Pathway X 0/0% AI
Anthem Silver Pathway X 0/0% AI

Anthem Blue Cross and Blue Shield Silver DirectAccess, a Multi-State Plan AI
Anthem Blue Cross and Blue Shield Gold DirectAccess, a Multi-State Plan AI

Anthem Logo and Company address is bracketed to allow for future change.

SCHEDULE OF BENEFITS:

Deductible amount option ranges are as shown in the schedule, for the different metal option offerings.

HMO/HSA ONLY – HSA specific deductible language is shown within asterisks as optional language that will only pull into HSA products chosen by the member.

Out of Pocket Limit (The most you will pay per calendar year) ranges (individual and family) are as shown in the schedule for the different metal option offerings.

Copayment amount ranges are as shown in the schedule for the different metal option offerings.

Coinsurance/Cost Share options ranges are as shown in schedule for the different metal option offerings.

Visit limits and **Day limit** ranges are as shown in the schedule for the different metal option offerings.

Ambulance – Cost share options ranges are as shown in the schedule.

Doctor visits - Cost share options ranges are as shown in the schedule. 3 different options for this benefit are available and are notated with the asterisk as optional. Only one option will appear in a member's contract based on the product selected.

Durable Medical Equipment - Cost share options ranges are as shown in the schedule.

Emergency room - Cost share options ranges are as shown in the schedule.

Urgent Care Center - Cost share options ranges are as shown in the schedule.

Home Health Care - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Private Duty Nursing - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Hospice Care - Cost share options ranges are as shown in the schedule.

Hospital Services - Cost share options ranges are as shown in the schedule.

Inpatient PM&R - Cost share options ranges are as shown in the schedule. The day limits range is as shown in the schedule for this benefit.

Mental Health/Substance Abuse – Cost share options ranges are as shown in the schedule.

Outpatient Diagnostic tests - Cost share options ranges are as shown in the schedule.

Outpatient Therapy Services - Cost share options ranges are as shown in the schedule. The visit limits range for each of the Therapy Services is as shown in the schedule for these benefits.

Prosthetics - Cost share options ranges are as shown in the schedule.

Skilled Nursing Care - Cost share options ranges are as shown in the schedule. The visit limits range is as shown in the schedule for this benefit.

Surgery - Cost share options ranges are as shown in the schedule.

Transplant HOTT - Cost share options ranges are as shown in the schedule. The dollar limits for the transplant transportation, lodging and unrelated donor search is as shown in the schedule for this benefit.

Prescription Drugs - Cost share options ranges are as shown in the schedule.

Pediatric Dental Services - Cost share options ranges are as shown in the schedule.

Pediatric Vision Services - Cost share options ranges are as shown in the schedule.

Eligible American Indiana statement – This statement will appear in all ON Exchange products as selected.

COVERED SERVICES:

Phone numbers and addresses – bracketed throughout the Covered Services section to allow us to update those if changes are necessary.

CLAIMS PAYMENT:

Deductible Calculation/Out-of-Pocket Limit Calculation –
HMO contract only: Two versions of language are provided within brackets for flexibility. One version for HMO, and one version for HMO/HSA. Only one version of language will appear in a member's contract, depending upon which product they select.

MEMBER GRIEVANCES:

HMO ON HIX contract only –

External Grievance – There are two versions of the External Grievance provision, indicated as optional language within asterisks. The first version is the IN State required provision for the HMO/HSA On Exchange product offering. The second version is the OPM required provision for the MSP On Exchange product offering. Only one version of this language will pull into a member's contract, depending on which product they select. At no time will the language in either version change without first being filed and approved by your department.

Changes in Premium – This provision is bracketed for flexibility, however, it will always appear as shown in a member's contract for ON EXCHANGE. If this value changes, we will file the new value with your department for approval.

Value-Added and Incentive Programs - This provision is bracketed for flexibility. Anthem is currently in discussions with a large corporation regarding an arrangement to offer an Exchange product that could be accompanied by incentives and value-added programs that will be provided by that corporation or its vendors and partners. The bracketed provision will appear as shown in the member's contract, or not appear at all, once a decision regarding this program is finalized.

Summary
5/8/2014 3:45:54 PM

Differences exist between documents.

New Document:	**Old Document:**
IN_ONHIX_HMHS(1-15)	FINAL APPROVED IN_ONHIX_HMHS(1-14)_rev 7-3-13
111 pages (1.02 MB)	111 pages (978 KB)
5/8/2014 3:44:54 PM	5/8/2014 3:44:29 PM
Used to display results.	

Get started: first change is on page 1.

No pages were deleted

How to read this report

Highlight indicates a change.
~~**Deleted**~~ indicates deleted content.
 indicates pages were changed.
 indicates pages were moved.

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

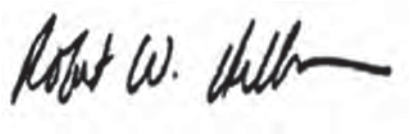
Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.



President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
  - Our company and services.
  - Our network of doctors and other health care providers.
  - your rights and responsibilities.
  - the rules of your health care plan.
  - the way your health plan works.
- Make a complaint or file an appeal about:
  - your health care plan.
  - any care you get.
  - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Network

	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,660]	$[0 - 13,200]

++

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

++

The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	$[0 - 50] $[0] $[0]	[0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	$[0 - 50] $[0] $[0]	[0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	$[0 - 50] $[0] $[0]	[0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	Coinsurance
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	Coinsurance
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	Copayment	Coinsurance
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	Copayment	Coinsurance
Tier 1 (90-day supply)	$[0 - 50]	% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).		
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
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Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

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Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see "Diagnostic and Preventive Services" section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See "Prosthodontic Services".

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.

- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be

considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the "Member Grievances" section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor's visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the "Where You Can Obtain Prescription Drugs" section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Helpful tip: See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
- Custodial Care, convalescent care or rest cures.
- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
- Gastric electrical stimulation.
- Hypnotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:

- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
- Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

For a Qualified Individual age 21 and over, the applicant must:

- Not be living in an institution
- Be capable of indicating intent
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange

For a Qualified Individual under age 21, the applicant must:

- Not be living in an institution
- Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
- Not be emancipated
- Not be receiving optional State supplementary payments (SSP); and
- Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract.

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- Network Providers include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles. You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - Health Care Management is the responsibility of the Network Provider.

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services (“CMS”). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers’ fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider’s charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem’s website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan’s Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider’s charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or

- The negotiated price that the Host Blue makes available to Anthem.

Often, this “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem’s Service Area

As mentioned under “Out-of Area Services” above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue’s local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem’s Service Area based on the Provider’s billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue’s payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting care in the right setting and how it affects preauthorization” paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- Predetermination – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- Post Service Clinical Claims Review – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- Emergent – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- Prospective – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- Continued Stay Review - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- Retrospective - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	Timeframe Requirement for Decision and Notification
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
   - an adverse utilization review determination; or
   - an adverse determination of Medical Necessity; or
   - a determination that a proposed service is Experimental/Investigational; or
2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one year after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If you do not agree with Our decision, you are entitled to request an independent, external review within one year of Our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714 with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your provider; you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review Our decision. If your claim was denied as not Medically Necessary or Experimental/Investigative, OPM will seek the binding opinion of an independent review organization (IRO). The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify

for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn Our decision, We will provide coverage or payment for your health care item or service and We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714 at any time. Additionally, the State of Indiana Department of Insurance may be able to help you file your appeal. Contact the Consumer Services Division of the Department of Insurance at (800) 622-4461 or (317) 232-2395, write to them at State of Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204 or electronically at www.ingov/idoi.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the Definitions section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the Eligibility and Enrollment section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the Covered Services section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- Alcoholism Treatment Facility – A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- Alternative Care Facility – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
  - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
  - Surgery
  - Therapy Services or rehabilitation

- Ambulatory Surgical Facility – A facility Provider, with an organized staff of Physicians that:
  - Is licensed as such, where required;
  - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  - Does not provide Inpatient accommodations; and
  - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- Birthing Center – a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
  1. constituted, licensed, and operated as set forth in the laws that apply;
  2. equipped to provide low-risk maternity care;
  3. adequately staffed with qualified personnel who
     a. provide care at childbirth;
     b. are practicing within the scope of their training and experience; and
     c. are licensed if required; and
  4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- Certified Advance Registered Nurse Practitioner – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- Certified Nurse Midwife – When services are supervised and billed for by an employer Physician.

- Certified Registered Nurse Anesthetist = Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- Certified Surgical Assistant – A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- Chiropractor – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- Day Hospital – A facility that provides day rehabilitation services on an Outpatient basis.

- Dialysis Facility – A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- Home Health Care Agency – A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- Home Infusion Facility – A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- Hospice – A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- Hospital – A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- Laboratory (Clinical) – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- Licensed Practical Nurse – When services are supervised and billed for by an employer Physician.

- Occupational Therapist – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- Outpatient Psychiatric Facility – A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- Pharmacy – An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- Physical Therapist – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- Physician –

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- Psychologist – A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- Registered Nurse – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- Registered Nurse First Assistant – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- Registered Nurse Practitioner – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- Regulated Physician's Assistant – When services are supervised and billed for by an employer Physician.

- Rehabilitation Hospital – A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- Respiratory Therapist (Certified) – A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- Skilled Nursing Facility = A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- Social Worker – A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- Speech Therapist (Licensed) - A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices

- Urgent Care Center – A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (SCP) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize = The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State [redacted]term State means each of the 50 States and the District of Columbia.

Subcontractor = The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription [redacted]Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent [redacted]term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer = The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services = Services and supplies used to promote recovery from an illness or injury. [redacted]

Tier One Drugs = This tier [redacted]low cost and preferred Drugs that may be [redacted]single source Brand [redacted]Drugs, or multi-source Brand [redacted]Drugs.

Tier Two Drugs = This tier [redacted]preferred Drugs [redacted]single source Brand [redacted]Drugs, or multi-source Brand [redacted]Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

What will I pay?

This chart shows the most you pay for deductibles and out-of-pocket expenses for covered services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Network Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

	Network		**Non-Network**	
	Per Individual	**Per Family**	**Per Individual**	**Per Family**
Calendar year deductible	$[0 - 5,000]	$[0 - 10,000]	$[0 - 15,000]	$[0 - 30,000]
The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]	$[0 - 30,000]	$[0 - 60,000]

	Network		**Non-Network**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Ambulance Services	$[0]	[0 - 40]%	$[0]	[0 - 40]%
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.			
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.			
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0-3] visits; care is then subject to Deductible and Coinsurance for subsequent	$[0 - 50]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
visits.				
Specialty Care Provider (SCP)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Other Office Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Durable Medical Equipment (medical supplies and equipment)	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Emergency room visits (Copayment waived if admitted)	$[0 - 200]	[0 - 40]%	$[0 - 200]	[0 - 40]%
Urgent Care Center	$[0 - 50]	[0 - 40]%	$[0 - 50]	[0 - 40]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year, Network and Non-Network combined, and a maximum of [164] visits per Member, per lifetime Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospice Care	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Hospital Services				
Inpatient	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Maximum limit of [60] days per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Mental Health & Substance Abuse				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Outpatient facility	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient office visit	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Diagnostic tests				
Laboratory	$[0]	[0 - 40]%	$[0]	[0 - 60]%
MRI, CT, & PET scan	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Radiology	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Speech, Occupational, and Manipulation Therapy** Limited to a maximum of [20] visits per Member, per Calendar Year for physical therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for occupational therapy, Network and Non-Network combined. Limited to a maximum of [20] visits per Member, per Calendar Year for speech therapy, Network and Non-Network combined. Limited to a maximum of [12] visits per Member, per Calendar Year for manipulation therapy, Network and Non-Network combined. **Cardiac Rehabilitation** Limited to a maximum of [36] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home	$[0]	[0 - 40]%	$[0]	[0 - 60]%

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits, per Member, per Calendar Year, Network and Non-Network combined. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.				
Preventive Care Services Network Care not subject to Deductible	$0	0%	$[0]	[0 - 60]%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Skilled Nursing Care Limited to a maximum of [90] visits per Member, per Calendar Year, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Surgery				
Inpatient admission	$[0 - 500] per admission	[0 - 40]%	$[0 - 1000] per admission	[0 - 60]%
Outpatient treatment	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Ambulatory Surgical Center	$[0]	[0 - 40]%	$[0]	[0 - 60]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.		Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging - $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant, Network and Non-Network combined.	$[0]	[0 - 40]%	$[0]	[0 - 60]% Covered transplant procedure charges at a Non-Network Transplant Provider Facility will NOT apply to

	Network		Non-Network	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
				your Out-of-Pocket Maximum.
Prescription Drugs	**Participating Pharmacy**		**Non-Participating Pharmacy**	
	Copayment	**Coinsurance**	**Copayment**	**Coinsurance**
Retail (30-day supply)				
Tier 1	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 2	$[0]	[0 - 40]% [after Calendar Year Deductible]	$[0]	[0 - 60]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 40]% after Calendar Year Deductible	$[0]	[0 - 60]% after Calendar Year Deductible
Mail Order				
Tier 1 (90-day supply)	$[0]	[0 - 40]% [after Calendar Year Deductible]	Not Covered	
Tier 2 (90-day supply)	$[0]	[0 - 40] % [after Calendar Year Deductible]	Not Covered	
Tier 3	$[0]	[0 - 40]% after Calendar Year	Not Covered	

Prescription Drugs	Participating Pharmacy		Non-Participating Pharmacy	
	Copayment	Coinsurance	Copayment	Coinsurance
(90-day supply) Tier 4 (30-day supply)	$[0]	Deductible [0 - 40]% after Calendar Year Deductible	Not Covered	
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, Participating Specialty Pharmacy, or Non-Participating Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.			

Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance	Pediatric Non-Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%	[0 - 10]%
Basic Restorative Services	[0 - 40]%	[0 - 40]%
Oral Surgery Services	[0 - 50]%	[0 - 50]%
Endodontic Services	[0 - 50]%	[0 - 50]%
Periodontal Services	[0 - 50]%	[0 - 50]%
Major Restorative Services	[0 - 50]%	[0 - 50]%
Prosthodontic Services	[0 - 50]%	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period.	[0 - 50]%	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

	Network Copayment	Non-Network Payment Allowance
Routine Eye Exam	$[0]	$[30]
[One per Calendar Year]		
Standard Plastic Lenses*		
[One per Calendar Year]		
Single Vision	$[0]	$[25]
Bifocal	$[0]	$[40]
Trifocal	$[0]	$[55]
Progressive	$[0]	$[40]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.		
Frames* (formulary) This Plan offers a selection of covered frames.	$[0]	$[45]
[One per Calendar Year]		
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.		
Elective (conventional and disposable)	$[0]	$[60]
Non-Elective	$[Covered in Full]	$[210]
[One per Calendar Year]		

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

The Non-Network payment allowance is the amount the Plan will pay for the services.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Services will only be Covered Services if rendered by Providers located in the state of Indiana unless:**

- **The services are for Emergency Care, Urgent Care and ambulance services; or**
- **The services are approved in advance by Anthem.**

Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered at the Network level, except for Emergency Care, Urgent Care, and ambulance services. Services which are not received from a PCP, SCP or another Network Provider will be considered a Non-Network Service, unless otherwise specified in this Contract. The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care, Urgent Care and ambulance services.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
  1) From your home, scene of accident or medical Emergency to a Hospital;
  2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
  3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

    - Observation and assessment by a psychiatrist weekly or more often,
    - Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a) The National Institutes of Health.
    b) The Centers for Disease Control and Prevention.
    c) The Agency for Health Care Research and Quality.
    d) The Centers for Medicare & Medicaid Services.
    e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum

Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).

- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for services rendered by Providers located outside the state of Indiana unless the services are for Emergency care, urgent care and ambulance services; or the services are approved in advance by Anthem.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
   - IgE RAST tests unless intradermal tests are contraindicated.
   - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
   - Food allergy test panels (including SAGE food allergy panels).
   - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related

means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the “Covered Services” section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.
    - applying skin creams in order to maintain skin tone.
    - other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the “Covered Services” section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage’s benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;

- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
- Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
- Surcharges for furnishing and/or receiving medical records and reports.
- Charges for doing research with Providers not directly responsible for your care.
- Charges that are not documented in Provider records.
- Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
- For membership, administrative, or access fees charged by Physicians or other Providers.

Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond the Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications or other forms or statements the Plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

This section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Services from Providers located in the state of Indiana; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care or Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Covered Services which are not obtained from a PCP, SCP or another Network Provider, or that are not an Authorized Service will be considered a Non-Network Service. The only exceptions are Emergency Care, Urgent Care, and ambulance services. In addition, certain services are not covered unless obtained from a Network Provider, see your **Schedule of Benefits**.

For services rendered by a Non-Network Provider, you are responsible for:

- Filing claims;
- Higher cost sharing amounts;
- Non-Covered Services;
- Services that are not Medically Necessary;
- The difference between the actual charge and the Maximum Allowable Amount, plus any Deductibles and/or Copayments/Coinsurances.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking services from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. If a service is received from a Non-Network Provider, you are responsible for making sure a claim is filed in order to receive benefits. Many Hospitals, Physicians, and other Providers, who are Non-Network Providers, will submit your claim for you. If you submit the claim yourself, you should use a claim form.

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that you receive. Please see the "Inter-Plan Arrangements" section of this Contract for additional information.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has

agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been Prior Authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers, contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out-of-pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate your out-of-pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, you may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

What Does Not Count Toward the Out-of-Pocket Limit

Not all amounts that you pay toward your health care costs are counted toward your Out-of-Pocket Limit. Some items never count toward the Out-of-Pocket Limit, and once your Out-of-Pocket Limit has been met, they are never paid at 100%. These items include but are not limited to:

- amounts over the Maximum Allowed Amount;
- amounts over any Contract maximum or limitation;
- expenses for services not covered under this Contract; and
- Coinsurance for any Non-Network Human Organ Tissue Transplant, which does not apply to the Non-Network Out-of-Pocket Limit.

Deductible Calculation

The Network and Non-Network Deductibles are separate and do not apply toward each other.

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance,* and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Network Out-of-Pocket Limit is satisfied, no additional Network Coinsurance will be required for the remainder of the calendar year.

Once the Non-Network Out-of-Pocket Limit is satisfied, no additional Non-Network Coinsurance will be required for the remainder of the calendar year, except for out-of-Network Human Organ and Tissue Transplant services.

Network and Non-Network Coinsurance and Out-of-Pocket Limits are separate and do not accumulate toward each other.

*The Non-Network Out-of Pocket Limit does not include Coinsurance for any out-of-Network Human Organ Tissue Transplant.

Network or Non-Network Providers

Your Cost-Share amount and Out-of-Pocket Limits may vary depending on whether you received services from a Participating or Non-Participating Provider. Please see the Schedule of Cost-Shares and Benefits in this Contract for your Cost-Share responsibilities and limitations, or call Customer Service to learn how this Plan's benefits or Cost-Share amounts may vary by the type of Provider you use.

Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits.

In some instances, you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating Cost-Share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service you receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the Covered Service is rendered. If We authorize a Network Cost-Share amount to apply to a Covered Service received from a Non-Network Provider, you also may still be liable for the difference between the Maximum Allowed Amount and the Non-Network Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize you to go to an available Non-Participating Provider for that Covered Service and We agree that the network Cost-Share will apply.

Your Plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost-Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, you may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

Payments may also be made to, and notice regarding the receipt and/or adjudication of claims, an Alternate Recipient, or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Payment Owed to You at Death

Any benefits owed at your death will be paid to your estate. If there is no estate, We may pay such benefits to a relative (by blood or by marriage) who appears to be equitably entitled to payment.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Claim forms will usually be available from most Providers. If forms are not available, send a written request for claim forms to Us or contact customer service and ask for claim forms to be sent to you. The form will be sent to you within 15 days. If you do not receive the forms, written notice of services rendered may be submitted to Us without the claim form. The same information that would be given on the claim form must be included in the written notice of claim. This includes:

- Name of patient
- Patient's relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician's signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically or filed on paper. "Clean claims" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

At our discretion, benefit will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those parties and be fully discharged from that portion of its liability.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Plan Information Practices Notice

The purpose of this information practices notice is to provide a notice to Members regarding the Plan's standards for the collection, use, and disclosure of information gathered in connection with the Plan's business activities.

- The Plan may collect personal information about a Member from persons or entities other than the Member.
- The Plan may disclose Member information to persons or entities outside of the Plan without Member authorization in certain circumstances.
- A Member has a right of access and correction with respect to all personal information collected by the Plan.
- A more detailed notice will be furnished to you upon request.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received
- The amount of the charges satisfied by your coverage
- The amount for which you are responsible (if any)
- General information about your appeals rights and for ERISA plans, information regarding the right to bring action after the Appeals Process.

Limitation of Actions

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum unless it is commenced no earlier than 60 days after We receive the claim or other request for benefits and within 3 years after expiration of the time within which notice of claim is required by the Contract. You must exhaust the Plan’s appeal procedures before filing a lawsuit or other legal action of any kind against the Plan, with the exception of the external appeals process.

Inter-Plan Arrangements

Anthem covers only limited healthcare services received outside of Our Service Area. For example, Emergency or Urgent Care obtained out of Our Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee (“Host Blue”) with which Anthem has a relationship (referred to as an “Inter-Plan Program”), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable Copayment or Coinsurance stated in this Contract.

Whenever you obtain covered services or supplies outside Our Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Our Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for Emergency or Urgent Care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Our Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment we would make if we were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, we may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the “Getting care in the right setting” paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by a Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	• Member must get Precertification. • If Member fails to get Precertification, Member may be financially responsible for service and/or setting in whole or in part. • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.

- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply

to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs -- The term Generic Drugs means a Prescription Drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a

Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider -- A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review

and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant -** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  - Provides skilled nursing and other services on a visiting basis in the Member's home; and

  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  - Skilled nursing services

  - Prescription Drugs

  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;

  2. rest care;

3. extended care;
4. convalescent care;
5. care of the aged;
6. Custodial Care;
7. educational care;
8. treatment of Mental Health Disorders;
9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.
- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.
- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Coverage under this Contract is guaranteed renewable, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal premium by the end of the grace period of any Premium due date. The Exchange may refuse renewal only under certain conditions.

Benefits under this Contract, including the Deductible, may vary depending on other medical expense insurance you may have.

If you have material modifications or questions related to your health insurance coverage, contact the Health Insurance Marketplace (Exchange) at www.healthcare.gov or 1-800-318-2596.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

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SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,660]	$[0 - 13,200]

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If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

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The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	**Copayment**	**Coinsurance**
Tier 1 (90-day supply)	$[0 - 50]	% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
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Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

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Eligible American Indians, as determined by the Exchange, are exempt from cost sharing requirements when Covered Services are rendered by an Indian Health Service (IHS), Indian Tribe, Tribal organization, or Urban Indian Organization (UIO) or through referral under contract health services. There will be no Member responsibility for American Indians when Covered Services are rendered by one of these providers.

[Optional Language]

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COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.

- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be

considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
  1) Replace all or part of a missing body part and its adjoining tissues; or
  2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

  1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
  2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
  3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
  4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
  5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
  6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
  7) Cochlear implants.
  8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
  9) Restoration prosthesis (composite facial prosthesis).
  10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

  1) Dentures, replacing teeth or structures directly supporting teeth;
  2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers.

    Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

The benefits, terms and conditions of this Contract are applicable to individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Subscriber

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2) Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic plan.
3) Be a United States citizen or national; or
4) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5) Be a resident of the State of Indiana; and meet the following applicable residency standards;

    For a Qualified Individual age 21 and over, the applicant must:

    - Not be living in an institution
    - Be capable of indicating intent
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

    For a Qualified Individual under age 21, the applicant must:

    - Not be living in an institution
    - Not be eligible for Medicaid based on receipt of federal payments for foster care and adoption assistance under Social Security
    - Not be emancipated
    - Not be receiving optional State supplementary payments (SSP); and
    - Reside in the Service Area of the Exchange

5) Agree to pay for the cost of Premium that Anthem requires;
6) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
7) Not be incarcerated (except pending disposition of charges);
8) Not be entitled to or enrolled in Medicare Parts A/B and or D;
9) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, a Qualified Individual's service area is the area in which the Qualified Individual:

1) Resides, intends to reside (including without a fixed address); or
2) is seeking employment (whether or not currently employed); or
3) has entered without a job commitment.

For Qualified Individuals under age 21, the service area is that of the parent or caretaker with whom the Qualified Individual resides.

For tax households with Members in multiple Exchange Service Areas:

1) If all of the members of a tax household are not living within the same Exchange service area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the tax filers meets the residency requirements.
2) If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange and be:

1) The Subscriber's legal spouse.
2) The Subscriber's Domestic Partner - Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.
    a) For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.
    b) A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.
    c) To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated on the Enrollment Application and submit the Enrollment Application to the Exchange. The Exchange will make the ultimate decision in determining eligibility of the Domestic Partner.
3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children who are under age 26;
4) Children for whom the Subscriber or the Subscriber's spouse is a legal guardian and who are under age 26.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Exchange must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify the Exchange if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Exchange may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

As established by the rules of the Exchange, Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during the annual open enrollment period or a special enrollment period for which the Qualified Individual has experienced a qualifying event.

An annual open enrollment period is provided for Qualified Individuals and enrollees. Qualified Individuals may enroll in a QHP, and enrollees may change QHPs at that time according to rules established by the Exchange.

American Indians are authorized to move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has 60 calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption;
- An individual, not previously a citizen, national, or lawfully present gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or HHS, or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move; and
- A Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide.

Qualified Individuals are free to move between metal levels during special enrollment periods.

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child.

A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you, and will be covered for an initial period of 31 days. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption. To continue coverage beyond the 31 day period you should submit a form to the Exchange, to add the child under the Subscriber's Contract within 60 days following the date of adoption or placement for adoption, along with the required Premium if additional Premium is needed to cover your adopted child.

Adding a Child due to Legal Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to the Exchange within 60 days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, you must request permission from the Exchange for your child to enroll under this Contract, and once approved by the Exchange We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond any Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective Date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective dates for special enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption. Advance Payments of the Premium Tax Credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2) In the case of marriage, or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. The Exchange must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify the Exchange of persons no longer eligible for services will not obligate Us to provide such services.

Acceptance of Premiums for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing the change to Single Coverage. The Exchange must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

Termination

This Section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1) The Member terminates his or her coverage with appropriate notice to the Exchange or the QHP.
2) The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.). In this case, the Exchange will send a notice to the Member. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date).
3) The Member fails to pay his or her Premium, and the grace period has been exhausted.
4) Rescission of the Member's coverage.
5) The QHP terminates or is decertified.
6) The Member changes to another QHP; or
7) The QHP may terminate coverage as permitted by the Exchange. The Member will be notified by the QHP as required by law.

"Grace Period" refers to either:

1) the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit; in this case, the last day of coverage will be the last day of the first month of the 3-month grace period; or
2) any other grace period.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1) In the case of termination initiated by the Member, the last day of coverage is:
    a) The termination date specified by the Member, if reasonable notice is provided;
    b) Fourteen days after the termination is requested, if the Member does not provide reasonable notice; or
    c) On a date determined by the Member's QHP issuer, if the Member's QHP issuer is able to implement termination in fewer than fourteen days and the Member requests an earlier termination effective date.
2) If the Member is newly eligible for Medicaid, CHIP, or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3) In the case where a Member is no longer eligible for coverage in a QHP through the Exchange (examples: divorce, dissolution of domestic partnership, overage dependent, move outside the Service Area etc.), the last day of coverage is the last day of the month following the month in which notice is sent by the Exchange, unless the Member requests an earlier termination effective date.
4) In the case of a termination for non-payment of Premium and the 3-month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the 3-month grace period.
5) In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day for which Premium payment is made consistent with existing State laws regarding grace periods.
6) In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
7) The day following the Member's death. When a Subscriber dies, the surviving spouse or Domestic Partner of the deceased Subscriber, if covered under the Contract, shall become the Subscriber.

Reasonable Notice is defined as fourteen (14) days prior to the requested effective date of termination.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria as a Qualified Individual continues to be met;
1) There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Contract; and
2) This Contract has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange or the QHP any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Nonrenewal will not affect an existing claim.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

If the Subscriber does not pay the full amount of the Premium by the Premium due date, the grace period is triggered. The grace period is an additional period of time during which coverage remains in effect and refers to either the 3-month grace period required for individuals receiving Advance Payments of the Premium Tax Credit (APTC) or for individuals not receiving the APTC, it refers to any other applicable grace period.

If the Subscriber does not pay the required Premium by the end of the grace period, the Contract is cancelled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Subscriber Receives APTC

If the Subscriber receiving the APTC has previously paid at least one month's Premium in a Benefit Period, We must provide a grace period of at least three consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the last day of the first month of the 3-month grace period. We must pay claims during the first month of the grace period but may pend claims in the second and third months subject to Anthem's right to cancel the Contract as provided herein. You will be liable to Us for the Premium payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the 3-month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Contract has a grace period of 31 days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due You give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or

- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or
    - an adverse determination of Medical Necessity; or
    - a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one year after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If you do not agree with Our decision, you are entitled to request an independent, external review within one year of Our decision. Contact the U.S. Office of Personnel Management (OPM) at (855) 318-0714 with any questions about your right to request external review. You may file a request online by visiting www.opm.gov/healthcare-insurance/multi-state-plan-program/. You can also send a written request to:

MSPP External Review
National Healthcare Operations
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

You or someone you name to act for you (your authorized representative) may file a request for external review. You may authorize someone to file on your behalf by naming them in your request.

All requests for external review will be handled as quickly as possible. However, if your situation is urgent, your request will be handled within 72 hours of its receipt. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your provider; you may experience pain that cannot be adequately controlled while you wait for a decision on the external review of your claim. You may request an expedited external review by sending an attestation from your doctor with your request for external review.

If you file a request for external review, OPM will review Our decision. If your claim was denied as not Medically Necessary or Experimental/Investigative, OPM will seek the binding opinion of an independent review organization (IRO). The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify

for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If your claim was denied based on the terms of coverage under this plan, OPM will render a binding determination. If either the independent review organization or OPM decides to overturn Our decision, We will provide coverage or payment for your health care item or service and We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

After you have filed your request for external review, you will receive instructions on how to supply additional information.

For questions about your rights, or for assistance, you can contact OPM at (855) 318-0714 at any time. Additionally, the State of Indiana Department of Insurance may be able to help you file your appeal. Contact the Consumer Services Division of the Department of Insurance at (800) 622-4461 or (317) 232-2395, write to them at State of Indiana Department of Insurance, Consumer Services Division, 311 W. Washington Street, Suite 300, Indianapolis, Indiana 46204 or electronically at www.ingov/idoi.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The rates for each Subscriber are guaranteed for the twelve (12) month period following the first day of the Benefit Year. The Premium for this Contract may change subject to, and as permitted by, applicable

law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an

independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program

features are not guaranteed under your Contract and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Advance Payments Of The Premium Tax Credit (APTC) - The term Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

American Indian – The term American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

Appeal – A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service – A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Benefit Year – The term Benefit Year means a Calendar Year for which a health plan provides coverage for health benefits.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial – The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance – Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your Deductible, your Coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible.

Cost-Share – The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure – Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care – Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical

personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1000, your plan won't pay anything until you've met your $1000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Summary of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent – A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service – A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person – A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) – With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions,

the term “stabilize” also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative – A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance – Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage – Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of prescription drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name prescription drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete prescription drugs from this Formulary from time to time. A description of the prescription drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs – The term Generic Drugs means a prescription drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug..

Grievance – Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;

- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care – A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card – A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service – Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount – The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity – Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare – The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse – is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Minimum Essential Coverage – The term Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program); coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of HHS recognizes.

Network Provider – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology – The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider – A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility – Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy – The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit – A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Summary of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-covered services. Refer to the Summary of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient – A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy – The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy – The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics Committee – a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process – The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) – Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year – The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium – The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug) – The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, “Caution: Federal law prohibits dispensing without a prescription.” This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order – A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician (“PCP”) – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider – A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:
    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility –** A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center –** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife –** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist –** Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on

Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant –** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility –** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency –** A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:
  - Provides skilled nursing and other services on a visiting basis in the Member's home; and
  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:
  - Skilled nursing services
  - Prescription Drugs
  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice –** A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital –** A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;
  2. has a staff with one or more Physicians available at all times;
  3. provides 24 hour nursing service;

4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

1. nursing care;

2. rest care;

3. extended care;

4. convalescent care;

5. care of the aged;

6. Custodial Care;

7. educational care;

8. treatment of Mental Health Disorders;

9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.

- **Occupational Therapist –** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.

- **Pharmacy –** An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.

- **Physical Therapist –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Physician –**

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or

2. any other legally licensed practitioner of the healing arts rendering services which are:

a. covered by the Plan;

b. required by law to be covered when rendered by such practitioner; and

c. within the scope of his or her license.

Physician does not include:

1. the Member; or

2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) –** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility –** A Provider constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

2. provides care supervised by a Physician;

3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center –** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Qualified Health Plan or QHP – The term Qualified Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Health Plan Issuer or QHP Issuer – The term Qualified Health Plan Issuer (QHP Issuer) means a health plan insurance issuer that offers a QHP in accordance with the certification from an Exchange.

Qualified Individual – The term Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

Recovery – A Recovery is money you receive from another, their insurer or from any Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs – The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area – The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage – Coverage for the Subscriber only.

Skilled Care – Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs – The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize – The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

State – The term State means each of the 50 States and the District of Columbia.

Subcontractor – The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to prescription drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Tax Dependent – The term Tax Dependent has the same meaning as the term dependent under the Internal Revenue Code.

Tax Filer – The term Tax Filer means an individual, or a married couple, who indicates that he, she or they expect.

3. To file an income tax return for the Benefit Year
4. If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
5. That no other taxpayer will be able to claim him, her or them as a tax dependent for the Benefit Year; and
6. That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

Therapy Services – Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs – This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs – This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs – This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs – This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.

Anthem BlueCross BlueShield

INDIVIDUAL CONTRACT

(herein called the "Contract")

[Product Names]

RIGHT TO EXAMINE THIS CONTRACT: You have 10 days to examine this Contract. If you are not satisfied with this Contract, You may return it to Us or the agent who sold it to you within 10 days after You receive it or have access to it electronically, whichever is earlier. Your premium will be refunded and this Contract will be void from its start.

Guaranteed Renewable: Renewability of coverage under this Contract is at the sole option of the Member. The Member may renew this Contract by payment of the renewal Premium by the end of the Grace Period of any Premium due date. The Plan may refuse renewal only under certain conditions, as explained in the Change in Coverage: Termination section.

Anthem Insurance Companies, Inc.
120 Monument Circle
Indianapolis, Indiana 46204

INTRODUCTION

Welcome to Anthem Blue Cross and Blue Shield! This Contract has been prepared by Us to help explain your coverage. Please refer to this Contract whenever you require health services. It describes how to access medical care, what health services are covered by Us, and what portion of the health care costs you will be required to pay.

This Contract, the application, and any amendments or riders attached shall constitute the entire Contract under which Covered Services and supplies are provided by Us.

This Contract should be read and re-read in its entirety. Since many of the provisions of this Contract are interrelated, you should read the entire Contract to get a full understanding of your coverage.

Many words used in the Contract have special meanings and start with a capital letter and are defined for you. Refer to the definitions in the **Definitions** section for the best understanding of what is being stated.

This Contract also contains **Noncovered Services/Exclusions,** so please be sure to read this Contract carefully.

President

How to Get Language Assistance

Anthem is committed to communicating with our Members about their health Plan, no matter what their language is. Anthem employs a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your Identification Card and a representative will be able to help you. Translation of written materials about your benefits can also be asked for by contacting Customer Service. TTY/TDD services also are available by dialing 711. A special operator will get in touch with Us to help with your needs.

Member Rights and Responsibilities

As a Member, you have certain rights and responsibilities when receiving your health care. You also have a responsibility to take an active role in your care. As your health care partner, We're committed to making sure your rights are respected while providing your health benefits. That also means giving you access to Our Network providers and the information you need to make the best decisions for your health and welfare.

These are your rights and responsibilities:

You have the right to:

- Speak freely and privately with your doctors and other health providers about all health care options and treatment needed for your condition. This is no matter what the cost or whether it is covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect and dignity.
- Expect Us to keep your personal health information private. This is as long as it follows state and Federal laws and Our privacy policies.
- Get the information you need to help make sure you get the most from your health plan, and share your feedback. This includes information on:
    - Our company and services.
    - Our network of doctors and other health care providers.
    - your rights and responsibilities.
    - the rules of your health care plan.
    - the way your health plan works.
- Make a complaint or file an appeal about:
    - your health care plan.
    - any care you get.
    - any covered service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future. This includes the right to have your doctor tell you how that may affect your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care provider about the cause of your illness, your treatment and what may result from it. If you don't understand certain information, you can choose a person to be with you to help you understand.

You have the responsibility to:

- Read and understand, as well as you can, all information about your health benefits or ask for help if you need it.
- Follow all health care plan rules and policies.
- Choose a network primary care physician (doctor), also called a PCP, if your health plan requires it.
- Treat all doctors, health care providers and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers. Call their office if you may be late or need to cancel.
- Understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- Tell your doctors or other health care providers if you don't understand any type of care you're getting or what they want you to do as part of your care plan.
- Follow the care plan that you have agreed on with your doctors and other health care providers.
- Give Us, your doctors and other health care providers the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health and insurance benefits you have in addition to your coverage with Us.
- Let Our Member Service department know if you have any changes to your name, address or family members covered under your Plan.

We are committed to providing high quality benefits and customer service to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Contract (your signed benefit Contract) and not by this Member Rights and Responsibilities statement.

If you need more information or would like to contact Us, please go to anthem.com and select Customer Support > Contact Us. Or call the Member Services number on your ID card.

TABLE OF CONTENTS

SCHEDULE OF COST SHARES & BENEFITS

This chart is an overview of your benefits for Covered Services, which are listed in detail in the "Covered Services" section. A list of services that are not covered can be found in the "Non-Covered Services/ Exclusions" section.

What will I pay?

This chart shows the most you pay for Deductibles and out-of-pocket expenses for Covered Services in one year of coverage. The Deductible applies to all Covered Services with a Coinsurance, including 0% Coinsurance, except for Preventive Care Services required by law and Pediatric Vision Services. For a detailed explanation of how your calendar year Deductibles and Out-of-Pocket Limits are calculated, see the "Claims Payment" section.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

	Network	
	Per Individual	**Per Family**
Calendar year deductible	$[0 - 6,600]	$[0 - 13,200]

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If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible.

[Optional Language]

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The most you will pay per calendar year	$[0 - 6,600]	$[0 - 13,200]

	Network	
	Copayment	**Coinsurance**
Ambulance Services	$[0]	[0 - 30]%
Dental Services (only when related to accidental injury or for certain Members requiring general anesthesia) Limited to a maximum of $[3,000] per Member, per dental accident	Copayment/Coinsurance determined by service rendered.	
Diabetic Medical Equipment & Supplies	Copayment/Coinsurance determined by service rendered.	

	Network	
	Copayment	**Coinsurance**
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. Copayment (not subject to Deductible) applies for first [0 - 3] visits; care is then subject to Deductible and Coinsurance for subsequent visits. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** Copayment applies to PCP office visit charge only. **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
**********		
Doctor visits **Primary Care Physician (PCP)** **Specialty Care Physician (SCP)** **Other Office Services**	 $[0 - 50] $[0] $[0]	 [0 - 30]% [0 - 30]% [0 - 30]%
[Optional Language] **********		
Durable Medical Equipment	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
(medical supplies and equipment)		
Emergency room visits (Copayment waived if admitted)	$[0 - 350]	[0 - 30]%
Urgent Care Center	$[0 - 50]	[0 - 30]%
Home Health Care Limited to a maximum of [90] visits per Member, per Calendar Year. Private Duty Nursing care provided in the home setting is limited to a maximum of [82] visits per Member, per Calendar Year and a maximum of [164] visits per Member, per lifetime.	$[0]	[0 - 30]%
Hospice Care	$[0]	[0 - 30]%
Hospital Services		
Inpatient	$[0 - 500] per admission	[0 - 30]%
Outpatient	$[0]	[0 - 30]%
Inpatient and Outpatient Professional Services	$[0]	[0 - 30]%
Inpatient Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis) – Limited to a maximum of [60] days per Member, per Calendar Year.	$[0]	[0 - 30]%
Mental Health & Substance Abuse		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient facility	$[0]	[0 - 30]%
Outpatient office visit	$[0]	[0 - 30]%
Outpatient Diagnostic tests		
Laboratory	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
MRI, CT, & PET scan	$[0]	[0 - 30]%
Radiology	$[0]	[0 - 30]%
Outpatient Therapy Services **Chemotherapy, radiation, and respiratory** **Physical, Occupational, Speech, and Manipulation therapy** **Physical Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Occupational Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Speech Therapy** – limited to a maximum of [20] visits per Member, per Calendar Year **Manipulation Therapy** – limited to a maximum of [12] visits per Member, per Calendar Year. **Cardiac Rehabilitation** Limited to a maximum of [36] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. **Pulmonary Rehabilitation** Limited to a maximum of [20] visits per Member, per Calendar Year. When rendered in the home, Home Health Care limits apply. If part of physical therapy, the Physical Therapy limit will apply instead of the limit listed here.	$[0]	[0 - 30]%
Preventive Care Services Network services required by law are not subject to Deductible.	$0	0%
Prosthetics – prosthetic devices, their repair, fitting, replacement and components	$[0]	[0 - 30]%
Skilled Nursing Care	$[0]	[0 - 30]%

	Network	
	Copayment	**Coinsurance**
Limited to a maximum of [90] visits per Member, per Calendar Year		
Surgery		
Inpatient admission	$[0 - 500] per admission	[0 - 30]%
Outpatient treatment	$[0]	[0 - 30]%
Ambulatory Surgical Center	$[0]	[0 - 30]%
Temporomandibular and Craniomandibular Joint Treatment	Benefits are based on the setting in which Covered Services are received.	
Transplant Human Organ & Tissue Network only - Transplant Transportation and Lodging $[10,000] maximum benefit limit per transplant Unrelated Donor Search - $[30,000] maximum benefit limit per transplant	$[0]	[0 - 30]%

Participating Pharmacy

Prescription Drugs	**Copayment**	**Coinsurance**
Retail (30-day supply)		
Tier 1	$[0 - 25]	[0 - 30]% [after Calendar Year Deductible]
Tier 2	$[0 - 55]	[0 - 30]% [after Calendar Year Deductible]
Tier 3	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
Mail Order		

Prescription Drugs	**Copayment**	**Coinsurance**
Tier 1 (90-day supply)	$[0 - 50]	[0 - 30]% [after Calendar Year Deductible]
Tier 2 (90-day supply)	$[0 - 137.50]	[0 - 30]% [after Calendar Year Deductible]
Tier 3 (90-day supply)	$[0]	[0 - 30]% after Calendar Year Deductible
Tier 4 (30-day supply) Prescription Drug coverage is limited to those Drugs listed on our Prescription Drug List (formulary).	$[0]	[0 - 30]% after Calendar Year Deductible
**********		
Orally Administered Cancer Chemotherapy	No Copayment/Coinsurance will apply to orally administered cancer chemotherapy you get from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.	
[Optional Language] **********		
**********		
Orally Administered Cancer Chemotherapy	Orally administered cancer chemotherapy is covered subject to applicable Prescription Drug Coinsurance when you get it from a Participating Pharmacy, Mail Order Pharmacy, or Participating Specialty Pharmacy. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage	

	for cancer chemotherapy that is administered intravenously or by injection.

[Optional Language]

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Pediatric Dental Services

The following dental benefits are available for Covered Services for Members through age 18. Covered Dental Services are subject to the same calendar year Deductible and Out-of-Pocket Limit as medical and amounts can be found on the first page of this Schedule of Cost-Shares and Benefits. Please see the Dental Services – Dental Care for Pediatric Members in the Covered Services section of this Contract for a detailed description of services.

	Pediatric Network Coinsurance
Diagnostic and Preventive Services	[0 - 10]%
Basic Restorative Services	[0 - 40]%
Oral Surgery Services	[0 - 50]%
Endodontic Services	[0 - 50]%
Periodontal Services	[0 - 50]%
Major Restorative Services	[0 - 50]%
Prosthodontic Services	[0 - 50]%
Dentally Necessary Orthodontic Care Services Subject to a 12 month waiting period	[0 - 50]%

Pediatric Vision Services

The following benefits are available to Members through age 18. Covered Vision Services are **not** subject to the calendar year Deductible and Out-of-Pocket Limit.

Coverage is only provided when services are received from a Network Provider.

	Copayment/Allowance
Routine Eye Exam	$[0]
[One per Calendar Year]	

Standard Plastic Lenses*	
[One per Calendar Year]	
Single Vision	$[0]
Bifocal	$[0]
Trifocal	$[0]
Progressive	$[0]
Lenses include factory scratch coating and UV coating at no additional cost. Polycarbonate and photochromic lenses are also covered at no extra cost. These options are only available when received from Network Providers.	
Frames*(formulary) This Plan offers a selection of covered frames.	$[0]
[One per Calendar Year]	
Contact Lenses*(formulary) This Plan offers a selection of covered contact lenses.	
[One per Calendar Year]	
Elective (conventional and disposable)	$[0]
Non-Elective	$0

*If you receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until you satisfy the benefit frequency listed.

COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by eligible Providers. **Care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider, to be covered except for Emergency Care, Urgent Care, and ambulance services, or services authorized by Us.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Contract, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Contract, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior Authorization or Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our Clinical Coverage Guidelines and Medical Policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

Benefits for Covered Services may be payable subject to an approved treatment plan created under the terms of this Contract. **Benefits for Covered Services are based on the Maximum Allowable Amount for such service. Our payment for Covered Services will be limited by any applicable Coinsurance, Copayment, Deductible, Benefit Period maximum, in this Contract.**

Ambulance Services (Air, Ground and Water)

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Medically Necessary ambulance services are a Covered Service when one or more of the following criteria are met:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, fixed wing, rotary wing or water transportation.
- You are taken:
    1) From your home, scene of accident or medical Emergency to a Hospital;
    2) Between Hospitals, including when We require you to move from an Non-Network Hospital to an Network Hospital; or
    3) Between a Hospital, Skilled Nursing Facility (ground transport only) or approved Facility.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility.

Non-Network Providers may bill you for any charges that exceed the Plan's Maximum Allowed Amount.

Ground Ambulance

Services are subject to Medical Necessity review by The Health Plan. All scheduled ground ambulance services for non-Emergency transports, not including acute facility to acute facility transport, must be Preauthorized.

Air and Water Ambulance

Air Ambulance Services are subject to medical necessity review by The Health Plan. The Health Plan retains the right to select the Air Ambulance provider. This includes fixed wing, rotary wing or water transportation.

Air ambulance services for non-Emergency Hospital to Hospital transports must be Preauthorized.

Hospital to Hospital Air Ambulance Transport

Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such Air Ambulance transport is Medically Necessary, for example, if transportation by ground ambulance would endanger Your health or the transferring Hospital does not have adequate facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate facilities.

Fixed and Rotary Wing Air Ambulance

Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance provider.

Autism Spectrum Disorders

Coverage is provided for the treatment of autism spectrum disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Autism spectrum disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Contract in conflict with the coverage described in this provision will not apply.

Behavioral Health Services

Mental Health and Substance Abuse Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Copayment.

Covered Services include but are not limited to:

- **Inpatient Services** – in a Hospital or any Facility that We must cover per state law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and detoxification.

- **Outpatient Services** - including office visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as partial hospitalization programs and intensive outpatient programs.

- **Residential Treatment** - which is specialized 24-hour treatment in a licensed Residential Treatment Center. It offers individualized and intensive treatment and includes:

- Observation and assessment by a psychiatrist weekly or more often,
- Rehabilitation, therapy, and education.

You can get Covered Services from the following Providers:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C) or
- Any agency licensed by the state to give these services, when we have to cover them by law.

Clinical Trials

Benefits include coverage for services given to you as a participant in an approved clinical trial if the services are Covered Services under this Contract. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   g) Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
      i. The Department of Veterans Affairs.
      ii. The Department of Defense.
      iii. The Department of Energy.
2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require you to use a Network Provider to maximize your benefits.

When a requested service is part of an approved clinical trial, it is a Covered Service even though it might otherwise be Investigational as defined by this Plan. All other requests for clinical trials services that are

not part of approved clinical trials will be reviewed according to our Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. We reserve our right to exclude any of the following services:

i. The Investigational item, device, or service, itself; or
ii. Items and services that given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
iii. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
iv. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

Dental Services – Dental Care for Pediatric Members

Your Dental Benefits

Anthem does not determine whether the dental services listed in this section are Medically Necessary to treat your specific condition or restore your dentition. There is a preset schedule of dental care services that are covered under this Contract. We evaluate the procedures submitted to Us on your claim to determine if they are a Covered Service under this Contract.

EXCEPTION: Claims for orthodontic care will be reviewed to determine if it was Dentally Necessary Orthodontic Care. See the section “Orthodontic Care” for more information.

Your dentist may recommend or prescribe other dental care services that are not covered, are cosmetic in nature, or exceed the benefit frequencies of this Contract. While these services may be necessary for your dental condition, they may not be covered by Us. There may be an alternative dental care service available to you that is covered under your Contract. These alternative services are called optional treatments. If an allowance for an optional treatment is available, you may apply this allowance to the initial dental care service prescribed by your dentist. You are responsible for any costs that exceed the allowance, in addition to any Coinsurance or Deductible you may have.

The decision as to what dental care treatment is best for you is solely between you and your dentist.

Pretreatment Estimates

A pretreatment estimate is a valuable tool for you and your dentist. It provides you and the dentist with an idea of what your out of pocket costs will be for the dental care treatment. This will allow the dentist and you to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontic, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but it is not required for you to receive benefits for covered dental care services.

A pretreatment estimate does not authorize treatment or determine its medical necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on your current eligibility and the Contract benefits in effect at the time the estimate is submitted to Us. This is an estimate only. Our final payment will be based on the claim that is submitted at the time of the completed dental care service(s). Submission of other claims, changes in your eligibility or changes to the Contract may affect our final payment.

You can ask your dentist to submit a pretreatment estimate for you, or you can send it to Us yourself. Please include the procedure codes for the services to be performed (your dentist can tell you what procedures codes). Pretreatment estimate requests can be sent to the address on your dental ID card.

We cover the following dental care services for Members up through age 18 when they are performed by a licensed dentist, and when necessary and customary as determined by the standards of

generally accepted dental practice. If there is more than one professionally acceptable treatment for your dental condition, We will cover the least expensive.

Diagnostic and Preventive Services

Oral Evaluations Any type of evaluation (checkup or exam) is covered 2 times per calendar year.

Comprehensive oral evaluations will be covered once per dental office, up to the 2-time per calendar year limit. Additional comprehensive oral evaluations from the same dental office will be covered as a periodic oral evaluation, and the 2-time per calendar year limit will apply.

Radiographs (X-rays)

- Bitewings – 1 series per 6-month period.
- Full Mouth (Complete Series) – Once per 60-month period.
- Panoramic – Once per 60-month period.
- Periapical(s).
- Occlusal.
- Vertical – Covered at 1 series (7 to 8) of bitewings per 6 month period.

Dental Cleaning (Prophylaxis) - Any combination of this procedure or periodontal maintenance (see "Periodontal Services" below) are covered 2 times per calendar year. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.

Fluoride Treatment (Topical application of fluoride) Covered 2 times per calendar year.

Fluoride Varnish Covered 2 times per calendar year.

Sealants or Preventive Resin Restorations - Any combination of these procedures is covered once per 24-month period for permanent first and second molars.

Space Maintainers.

Recement Space Maintainer.

Emergency Treatment - Emergency (palliative) treatment for the temporary relief of pain or infection.

Basic Restorative Services

Consultations with a dentist other than the one providing treatment.

Amalgam (silver) Restorations - Treatment to restore decayed or fractured permanent or primary teeth posterior (back) teeth.

Composite (white) Resin Restorations - Treatment to restore decayed or fractured permanent or primary teeth anterior (front) teeth.

Re-cement inlay and crown.

Pre-fabricated or Stainless Steel Crown (primary or permanent tooth) - Covered 1 time per 60-month period through the age of 14.

Protective Restoration.

Pin Retention – per tooth, in addition to restoration.

Other Adjunctive General Services

- Treatment of drug injection, by report
- Treatment of complications (post-surgical) unusual circumstances

Endodontic Services

Endodontic Therapy on Primary Teeth

- Pulpal Therapy – Anterior and posterior teeth (excluding final restoration). Limited to primary incisor teeth for Members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Therapeutic Pulpotomy - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service, since it is considered part of the root canal procedure and benefits are not payable separately.

Endodontic Therapy on Permanent Teeth

- Root Canal Therapy
- Root Canal Retreatment

Other Endodontic Treatments - Limited to once per tooth per lifetime

- Pulpal regeneration
- Apexification
- Apicoectomy
- Root amputation – per root
- Hemisection (including any root removal) – not including root canal therapy.
- Retrograde filling

Periodontal Services

Periodontal Maintenance A procedure that includes removal of bacteria from the gum pocket areas, scaling and polishing of the teeth, periodontal evaluation and gum pocket measurements for patients who have completed periodontal treatment.

Benefits for any combination of this procedure and dental cleanings (see “Diagnostic and Preventive Services” section) are limited to 4 times per 12 months combined with adult prophylaxis after the completion of active periodontal therapy.

Basic Non-Surgical Periodontal Care Treatment of diseases of the gingival (gums) and bone supporting the teeth.

- Periodontal scaling & root planning is covered if the tooth has a pocket depth of 4 millimeters or greater. Limited to once per 24 months.
- Full mouth debridement.

Crown Lengthening.

Complex Surgical Periodontal Care Surgical treatment of diseases of the gingival (gums) and bone supporting the teeth. The following services are considered complex surgical periodontal services:

- Gingivectomy/gingivoplasty;
- Gingival flap;
- Apically positioned flap;
- Osseous surgery;
- Bone replacement graft;
- Pedicle soft tissue graft;
- Free soft tissue graft;
- Subepithelial connective tissue graft;
- Soft tissue allograft;
- Combined connective tissue and double pedicle graft;
- Distal/proximal wedge - Covered on natural teeth only

Complex surgical periodontal services are limited as follows:

- Only one complex surgical periodontal service is covered per 36-month period per single or multiple teeth in the same quadrant if the pocket depth of the tooth is 5 millimeters or greater.

Oral Surgery Services

Basic Extractions

- Extraction of erupted tooth or exposed root

Complex Surgical Extractions

- Surgical removal of erupted tooth
- Surgical removal of impacted tooth
- Surgical removal of residual tooth roots

Surgical removal of third molars are only covered if the removal is associated with symptoms of oral pathology.

Other Complex Surgical Procedures

- Alveoloplasty
- Vestibuloplasty
- Removal of exostosis-per site
- Surgical reduction of osseous tuberosity

Other Oral Surgery Procedures

- Incision and drainage of abscess (intraoral soft tissue)
- Collection and application of autologous product
- Excision of pericoronal gingiva
- Coronectomy
- Tooth reimplantation of accidentally evulsed or displaced tooth
- Surgical access of unerupted tooth
- Suture of recent small wounds up to 5 cm

Adjunctive General Services

- Intravenous Conscious Sedation, IV Sedation, and General Anesthesia

Major Restorative Services

Inlays Benefit shall equal an amalgam (silver) restoration for the same number of surfaces.

If an inlay is performed to restore a posterior (back) tooth with a metal, porcelain, or any composite (white) based resin material, the patient must pay the difference in cost between the Maximum Allowed Amount for the Covered Service and inlay, plus any Deductible, Copayment, and/or Coinsurance that applies.

Onlays and/or Permanent Crowns Covered once every 60 months if the tooth has extensive loss of natural tooth structure due to decay or tooth fracture such that a restoration cannot be used to restore the tooth. Covered for permanent teeth only. We will pay up to the Maximum Allowed Amount for a porcelain to noble metal crown. You must pay the difference in cost between the porcelain to noble metal crown and the optional treatment, plus any Deductible and/or Coinsurance.

Implant Crowns See “Prosthodontic Services”.

Recement Inlay, Onlay, and Crowns Covered 6 months after initial placement.

Crown/Inlay/Onlay Repair Covered 6 months after initial placement.

Restorative cast post and core build-up, including 1 post per tooth and 1 pin per surface Covered once every 60 months when necessary to retain an indirectly fabricated restoration due to extensive loss of actual tooth structure due to caries or fracture.

Prefabricated post and core in addition to crown Covered once per tooth every 60 months.

Occlusal guards Covered once every 12 months for Members age 13 through 18.

Prosthodontic Services

Tissue Conditioning.

Reline and Rebase Covered once per 36-month period when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge).

Repairs, Replacement of Broken Artificial Teeth, Replacement of Broken Clasp(s) Covered when:

- The prosthetic appliance (denture, partial or bridge) is the permanent prosthetic appliance;
- At least 6 months have passed since the initial placement of the prosthetic appliance (denture, partial or bridge); and
- When the submitted narrative from the treating dentist supports the procedure.

Denture Adjustments Covered when:

- The denture is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the denture.

Partial and Bridge Adjustments Covered when:

- The partial or bridge is the permanent prosthetic appliance; and
- At least 6 months have passed since the initial placement of the partial or bridge.

Removable Prosthetic Services (Dentures and Partials) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If 5 years have passed since the last covered removable prosthetic appliance (denture or partial) and the existing denture or partial cannot be repaired or adjusted.

Fixed Prosthetic Services (Bridge) Covered once every 60 months:

- For Members age 16 through 18;
- For the replacement of extracted (removed) permanent teeth;
- If no more than 3 teeth are missing in the same arch;
- A natural, healthy, sound tooth is present to serve as the anterior and posterior retainer;
- No other missing teeth in the same arch that have not been replaced with a removable partial denture;
- If none of the individual units of the bridge has been covered previously as a crown or cast restoration in the last 5 years;
- If 5 years have passed since the last covered removable prosthetic appliance (bridge) and the existing bridge cannot be repaired or adjusted.

If there are multiple missing teeth, benefits may only be paid for a removable partial denture if it would be the least costly, commonly performed course of treatment. Any optional benefits are subject to all contract limits on the Covered Service.

Recement Fixed Prosthetic.

Single Tooth Implant Body, Abutment and Crown Covered once per 60 months. Coverage includes only the single surgical placement of the implant body, implant abutment and implant/abutment supported crown.

Some adjunctive implant services may not be covered. We recommend that you get a pretreatment estimate to estimate the amount of payment before you begin treatment.

Orthodontic Care

Orthodontic care is care for the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. We will only cover Dentally Necessary orthodontic care.

To be considered Dentally Necessary at least one of the following must be present:

a. There is spacing between adjacent teeth which interferes with the biting function;
b. There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when you bite;
c. Positioning of the jaws or teeth impair chewing or biting function;
d. On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
e. Based on a comparable assessment of items a through d, there is an overall orthodontic problem that interferes with the biting function.

You or your orthodontist should send your treatment plan to us for you start treatment to find out if it will be covered under this Plan.

Benefits may include the following:

- Limited Treatment - Treatments which are not full treatment cases and are usually done for minor tooth movement.
- Interceptive Treatment - A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- Comprehensive (complete) Treatment - Full treatment includes all radiographs, diagnostic casts / models, appliances and visits.
- Removable Appliance Therapy - An appliance that is removable and not cemented or bonded to the teeth.
- Fixed Appliance Therapy - A component that is cemented or bonded to the teeth.
- Other Complex Surgical Procedures - Surgical exposure of impacted or unerupted tooth for orthodontic reasons or surgical repositioning of teeth.

Treatment that is already in progress with appliances placed before you were covered by this Plan will be covered on a pro-rated basis.

Benefits do not include:

1) Monthly treatment visits that are inclusive of treatment cost;
2) Repair or replacement of lost/broken/stolen appliances;
3) Orthodontic retention/retainer as a separate service;
4) Retreatment and/or services for any treatment due to relapse;
5) Inpatient or outpatient hospital expenses (please refer to your medical coverage to determine if this is a covered medical service); and
6) Provisional splinting, temporary procedures or interim stabilization of teeth.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Plan in order to receive ongoing payments for your orthodontic treatment.

Payments for treatment are made: (1) when treatment begins (appliances are installed), and (2) at six month intervals thereafter, until treatment is completed or this Plan's coverage ends.

Before treatment begins, the treating orthodontist should send a pre-treatment estimate to us. An Estimate of Benefits form will be sent to you and your orthodontist indicating the estimated Maximum Allowed Amount, including any amount you may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After we have verified your Plan benefit and your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to you and your orthodontist. This again serves as the claim form to be sent in 6 months after the appliances are placed.

Dental Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Accident Related Dental Services

Outpatient Services, Physician Home Visits and Office Services, Emergency Care and Urgent Care services for dental work and oral surgery are covered if they are for the initial repair of an injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the patient's condition. Injury as a result of chewing or biting is not considered an accidental injury. "Initial" dental work to repair injuries due to an accident means performed within 12 months from the injury, or as reasonably soon thereafter as possible and includes all examinations and treatment to complete the repair. For a child requiring facial reconstruction due to dental related injury, there may be several years between the accident and the final repair.

Covered Services for accidental dental include, but are not limited to:

- Oral examinations;
- X-rays;
- Tests and laboratory examinations;
- Restorations;
- Prosthetic services;
- Oral surgery;
- Mandibular/Maxillary reconstruction;
- Anesthesia.

Other Dental Services

Anesthesia and Hospital charges for dental care, for a Member less than 19 years of age or a Member with intellectual or physical disability, are covered if the Member requires dental treatment to be given in a Hospital or Outpatient Ambulatory Surgical Facility. The Indications for General Anesthesia, as published in the reference manual of the American Academy of Pediatric Dentistry, should be used to determine whether performing dental procedures is necessary to treat the Member's condition under general anesthesia. This coverage does not apply to treatment for temporal mandibular joint disorders (TMJ).

General anesthesia is a Drug, gas or other modality that, when administered, causes a complete loss of sensation and a loss of consciousness. Benefits are not provided for routine dental services.

NOTE: Benefits are not provided for routine dental care, unless otherwise specified as a Covered Service in this Contract.

Diabetic Equipment, Education and Supplies

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, and Benefit Limitation information.

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Diabetes Self Management Training is covered for an individual with insulin dependent diabetes, non-insulin dependent diabetes, or elevated blood glucose levels induced by pregnancy or another medical condition when:

- Medically Necessary;
- Ordered in writing by a Physician or a podiatrist; and
- Provided by a Health Care Professional who is licensed, registered, or certified under state law.

For the purposes of this benefit, a "Health Care Professional" means the Physician or podiatrist ordering the training or a Provider who has obtained certification in diabetes education by the American Diabetes Association.

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See “Medical Supplies, Durable Medical Equipment and Appliances” and “Physician Home Visits and Office Services”.

Screenings for gestational diabetes are covered under “Preventive Care”.

Diagnostic Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Diagnostic services are tests or procedures generally performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services is limited to the following:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.
- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG’s are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.

- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP).
- Visual evoked potentials (VEP).
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

Central supply (IV tubing) or pharmacy (dye) necessary to perform tests are covered as part of the test, whether performed in a Hospital or Physician's office.

Emergency Care and Urgent Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care you get from a Non-Network Provider will be covered as a Network service. When you receive Emergency Care rendered by a Non-Network Provider, by law, the Non-Network Provider cannot charge you any more than the applicable Coinsurance, Copayment or Deductible under your Plan.

The Maximum Allowed Amount for Emergency Care from a Non-Network Provider will be the greatest of the following:

1. The amount negotiated with Network Providers for the Emergency service;
2. The amount for the Emergency service calculated using the same method we generally use to determine payments for Non-Network services but substituting the Network cost-sharing for the Non-Network cost-sharing; or
3. The amount that would be paid under Medicare for the Emergency service.

In addition, if you contact your Physician and are referred to a Hospital emergency room, benefits will be provided at the level for Emergency Care. Hospitals are open to treat an Emergency 24 hours a day, 7 days a week. **Follow-up care is not considered Emergency Care.**

Benefits are provided for treatment of Emergency Medical Conditions and Emergency screening and Stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an Emergency Medical Condition based upon the patient's presenting symptoms and conditions. Benefits for Emergency Care include facility costs and Physician services, and supplies and Prescription Drugs charged by that facility.

For an Inpatient admission following Emergency Care, Precertification is not required. However, you must notify Us or verify that your Physician has notified Us of your admission within 48 hours or as soon as possible within a reasonable period of time. When We are contacted, you will be notified whether the Inpatient setting is appropriate, and if appropriate, the number of days considered Medically Necessary. By calling Us, you may avoid financial responsibility for any Inpatient care that is determined to be not Medically Necessary under your Plan. If your Provider does not have a contract with Us or is a BlueCard Provider, you will be financially responsible for any care We determine is not Medically Necessary.

Care and treatment provided once you are Stabilized is not Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be

considered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

Often an urgent rather than an Emergency medical problem exists. All Covered Services obtained at Urgent Care Centers are subject to the Urgent Care Copayment/Coinsurance. Urgent Care services can be obtained from a Network or Non-Network Provider. Urgent Care Services rendered by a Non-Network Urgent Care Provider will be considered as a Network service; however the Member **may** be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Copayment/Coinsurance or Deductible. If you experience an accidental injury or a medical problem, the Plan will determine whether your injury or condition is an Urgent Care or Emergency Care situation for coverage purposes, based on your diagnosis and symptoms.

An Urgent Care medical problem is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees). An Urgent Care medical problem is one that is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorizes you to go to an emergency room, your care will be paid at the level specified in the Schedule of Cost-Shares and Benefits for Emergency Room Services.

Home Care Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered services are those performed by a Home Health Care Agency or other Provider in your residence. Home Health Care includes professional, technical, health aide services, supplies, and medical equipment. The Member must be confined to the home for medical reasons, and be physically unable to obtain needed medical services on an Outpatient basis. Covered Services include but are not limited to:

- Intermittent Skilled Nursing Services (by an R.N. or L.P.N.)
- Medical/Social Services
- Diagnostic Services
- Nutritional Guidance
- Home Health Aide Services. The Member must be receiving skilled nursing or therapy. Services must be furnished by appropriately trained personnel employed by the Home Health Care Provider. Other organizations may provide services only when approved by Us, and their duties must be assigned and supervised by a professional nurse on the staff of the Home Health Care Provider.
- Therapy Services (except for Manipulation Therapy which will not be covered when rendered in the home). Home Care Visit limits specified in the Schedule of Cost-Shares and Benefits for Home Care Services apply when Therapy Services are rendered in the home.
- Medical/Surgical Supplies
- Durable Medical Equipment
- Prescription Drugs (only if provided and billed by a Home Health Care Agency)
- Private Duty Nursing

Non-Covered Services include, but are not limited to:

- Food, housing, homemaker services and home delivered meals.

- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)
- Services provided by Registered Nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which the patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

Home infusion therapy will be paid only if you obtain prior approval from Our Home Infusion Therapy Administrator (if applicable). Benefits for home infusion therapy include a combination of nursing, durable medical equipment and pharmaceutical services which are delivered and administered intravenously in the home. Home IV therapy includes but is not limited to: injections (intra-muscular, subcutaneous, continuous subcutaneous), Total Parenteral Nutrition (TPN), Enteral nutrition therapy, Antibiotic therapy, pain management and chemotherapy.

Hospice Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Are those Covered Services and supplies listed below if part of an approved treatment plan and when rendered by a Hospice Provider for the palliative treatment of pain and other symptoms associated with a terminal disease. Palliative care means appropriate care which controls pain and relieves symptoms, but is not meant to cure a terminal illness. Please refer to the Schedule of Cost-Shares and Benefits for details on the payment levels and limits for services and supplies listed below. You should also refer to the Exclusions section for services that are not covered.

- Care rendered by an Interdisciplinary team with the development and maintenance of an appropriate plan of care.
- Short-term inpatient facility care when required in periods of crisis or as respite care.
- Skilled nursing services, home health aide services provided by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous hydration and feeding tubes.
- Physical therapy, occupational therapy, speech therapy and respiratory therapy.
- Pharmaceuticals, medical equipment and supplies necessary for the palliative treatment of your condition including oxygen and related respiratory therapy supplies.

In order to receive Hospice benefits (1) your physician and the Hospice medical director must certify that you are terminally ill and generally have less than 6 months to live, and (2) your physician must consent to your care by the Hospice and must be consulted in the development of your treatment plan. The Hospice must maintain a written treatment plan on file and furnish to us upon request.

Additional Covered Services to those listed above (such as chemotherapy and radiation therapy) when provided for palliation of the effects of a terminal illness are available while in Hospice. Benefits for these additional Covered Services, which are described in other parts of this Contract, are provided as set forth in other parts of this Contract.

Inpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Inpatient Services include:

- Charges from a Hospital, Skilled Nursing Facility (SNF) or other Provider for room, board and general nursing services.
- Ancillary (related) services.
- Professional services from a Physician while an Inpatient.

Room, Board, and General Nursing Services

- A room with two or more beds.
- A private room. The private room allowance is the Hospital's average semi-private room rate unless it is Medically Necessary that you use a private room for isolation and no isolation facilities are available.
- A room in a special care unit approved by Us. The unit must have facilities, equipment and supportive services for intensive care of critically ill patients.

Ancillary (Related) Services

- Operating, delivery and treatment rooms and equipment.
- Prescribed drugs.
- Anesthesia, anesthesia supplies and services given by an employee of the Hospital or other Provider.
- Medical and surgical dressings, supplies, casts and splints;
- Diagnostic Services.
- Therapy Services.

Professional Services

- **Medical care** visits limited to one visit per day by any one Physician.
- **Intensive medical care** for constant attendance and treatment when your condition requires it for a prolonged time.
- **Concurrent** care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery. Care by two or more Physicians during one Hospital stay when the nature or severity of your condition requires the skills of separate Physicians.
- **Consultation** which is a personal bedside examination by another Physician when requested by your Physician. Staff consultations required by Hospital rules; consultations requested by the patient; routine radiological or cardiographic consultations; telephone consultations; EKG transmittal via phone are excluded.
- **Surgery and the administration of general anesthesia.**
- **Newborn exams**. A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Copayment Waiver

When a Member is transferred from one Hospital or other facility to another Hospital or other facility on the same day, any Copayment per admission in the Schedule of Cost-Shares and Benefits is waived for the second admission.

Maternity Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Maternity Services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services for normal pregnancy, complications of pregnancy, miscarriage, therapeutic abortion, and ordinary routine nursery care for a healthy newborn.

NOTE: Therapeutic abortions are Covered Services only when a woman becomes pregnant through an act of rape or incest, or when necessary to avert the pregnant woman's death or a substantial and irreversible impairment of a major bodily function of the pregnant woman.

One Deductible and Copayment will apply to both the mother and the newborn child for Maternity Services **only** if the newborn care is routine nursery care.

NOTE: If a newborn child is required to stay as an Inpatient past the mother's discharge date, the services for the newborn child will then be considered a separate admission from the Maternity and an ordinary routine nursery admission, and will be subject to a separate Inpatient Copayment.

Covered Services include two at-home post delivery care visits at your residence by a Physician or Nurse when performed no later than forty-eight (48) hours following you and your newborn child's discharge from the hospital. Coverage for this visit includes, but is not limited to:

1) Parent education;
2) Physical assessments;
3) Assessment of the home support system;
4) Assistance and training in breast or bottle feeding; and
5) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office. In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

1) Phenylketonuria;
2) Hypothyroidism;
3) Hemoglobinopathies, including sickle cell anemia;
4) Galactosemia;
5) Maple Syrup urine disease;
6) Homocystinuria;
7) Inborn errors of metabolism that result in mental retardation and that are designated by the state department of health;
8) Physiologic hearing screening examination for the detection of hearing impairments;
9) Congenital adrenal hyperplasia;
10) Biotinidase deficiency;
11) Disorders detected by tandem mass spectroscopy or other technologies with the same or greater capabilities as tandem mass spectrometry.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Under federal law, health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, less than 96 hours following a delivery by cesarean section. However, the issuer may pay for a short stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, an issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain Precertification. For information on Precertification, contact Us by calling the Customer Service telephone on the back of your Identification Card**.**

Medical Supplies, Durable Medical Equipment, and Appliances

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

The supplies, equipment and appliances described below are Covered Services under this benefit. If the supplies, equipment and appliances include comfort, luxury, or convenience items or features which exceed what is Medically Necessary in your situation or needed to treat your condition, reimbursement will be based on the Maximum Allowable Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowable Amount for the standard item that is a Covered Service is your responsibility. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair adequately accommodates your condition.

Repair, adjustment and replacement of purchased equipment, supplies or appliances as set forth below may be covered, as approved by Us. The repair, adjustment or replacement of the purchased equipment, supply or appliance is covered if:

- the equipment, supply or appliance is a Covered Service;
- the continued use of the item is Medically Necessary;
- there is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).

In addition, replacement of purchased equipment, supplies or appliance may be covered if:

1) The equipment, supply or appliance is worn out or no longer functions.
2) Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
3) Individual's needs have changed and the current equipment or appliance is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
4) The equipment, supply or appliance is damaged and cannot be repaired

Benefits for repairs and replacement do not include the following:

- Repair and replacement due to misuse, malicious breakage or gross neglect.
- Replacement of lost or stolen items.

We may establish reasonable quantity limits for certain supplies, equipment or appliances described below. A detailed listing of supplies, equipment or appliances that are not covered by Us, including quantity limits, is available to you upon request. Please call the Customer Service number on your Identification Card. This list is subject to change.

Covered Services include, but are not limited to:

- **Medical and Surgical Supplies** – Certain supplies and equipment for the management of disease that We approve are covered under the Prescription Drug benefit, if any. These supplies are considered as a medical supply benefit if the Member does not have Prescription Drug benefits through Anthem, or if the supplies, equipment or appliances are not received from the Mail Service used by Anthem or from a Network Pharmacy: Syringes, needles, oxygen, surgical dressings, splints and other similar items which serve only a medical purpose. Covered Services also include Prescription Drugs and biologicals that cannot be self-administered and are provided in a Physician’s office.

Covered Services do not include items usually stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Covered Services may include, but are not limited to:

1) Allergy serum extracts;
2) Chem strips, Glucometer, and lancets;
3) Clinitest;
4) Needles/syringes;
5) Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

Non-Covered Services include, but are not limited to:

1) Adhesive tape, bandages, and cotton tipped applicators;
2) Arch supports;
3) Doughnut cushions;
4) Hot packs, ice bags;
5) Vitamins;
6) Medijectors
7) Elastic stockings or supports;
8) Gauze and dressings

If you have any questions regarding whether a specific medical or surgical supply is covered or want to obtain a detailed list, call the customer service number on the back of your Identification Card.

Durable medical equipment – The rental (or, at Our option, the purchase) of durable medical equipment prescribed by a Physician or other Provider. Durable medical equipment is equipment which can withstand repeated use; i.e., could normally be rented, and used by successive patients; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. Examples include but are not limited to wheelchairs, crutches, hospital beds, and oxygen equipment. Rental costs must not be more than the purchase price. The costs for delivering and installing the equipment are Covered Services. Payment for related supplies is a Covered Service only when the equipment is a rental, and medically fitting supplies are included in the rental; or the equipment is owned by the Member; medically fitting supplies may be paid separately. Equipment should be purchased when it costs more to rent it than to buy it. Repair of medical equipment is covered.

Covered Services may include, but are not limited to:

1) Hemodialysis equipment;
2) Crutches and replacement of pads and tips;
3) Pressure machines;
4) Infusion pump for IV fluids and medicine;
5) Glucometer;
6) Tracheotomy tube;
7) Cardiac, neonatal and sleep apnea monitors;
8) Augmentive communication devices are covered when We approve based on the Member's condition.

Non-covered items include, but are not limited to:

1) Air conditioners;
2) Ice bags/coldpack pump;
3) Raised toilet seats;
4) Rental of equipment if the Member is in a Facility that is expected to provide such equipment;
5) Translift chairs;
6) Treadmill exerciser;
7) Tub chair used in shower.

If you have any questions regarding whether a specific durable medical equipment is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic appliances** – Artificial substitutes for body parts and tissues and materials inserted into tissue for functional or therapeutic purposes. Covered Services include purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that:
    1) Replace all or part of a missing body part and its adjoining tissues; or
    2) Replace all or part of the function of a permanently useless or malfunctioning body part.

  Prosthetic devices should be purchased, not rented, and must be Medically Necessary. Applicable taxes, shipping and handling are also covered.

  Covered Services may include, but are not limited to:

    1) Aids and supports for defective parts of the body including but not limited to internal heart valves, mitral valve, internal pacemaker, pacemaker power sources, synthetic or homograph vascular replacements, fracture fixation devices internal to the body surface, replacements for injured or diseased bone and joint substances, mandibular reconstruction appliances, bone screws, plates, and vitallium heads for joint reconstruction.
    2) Left Ventricular Artificial Devices (LVAD) (only when used as a bridge to a heart transplant).
    3) Breast prosthesis whether internal or external, following a mastectomy, and four surgical bras per Benefit Period, as required by the Women's Health and Cancer Rights Act. Maximums for Prosthetic devices, if any, do not apply.
    4) Replacements for all or part of absent parts of the body or extremities, such as artificial limbs, artificial eyes, etc.; Coverage for a prosthetic limb (artificial leg or arm) is described in more detail below;
    5) Intraocular lens implantation for the treatment of cataract or aphakia. Contact lenses or glasses are often prescribed following lens implantation and are Covered Services. (If cataract extraction is performed, intraocular lenses are usually inserted during the same operative session). Eyeglasses (for example bifocals) including frames or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury; the first pair of contact lenses or eyeglasses are covered. The donor lens inserted at the time of surgery is not considered a contact lens, and is not considered the first lens following surgery. If the injury is to one eye or if cataracts are removed from only one eye and the Member selects eyeglasses and frames, then reimbursement for both lenses and frames will be covered.
    6) Artificial gut systems (parenteral devices necessary for long term nutrition in cases of severe and otherwise fatal pathology of the alimentary tract – formulae and supplies are also covered).
    7) Cochlear implants.
    8) Colostomy and other ostomy (surgical construction of an artificial opening) supplies directly related to ostomy care.
    9) Restoration prosthesis (composite facial prosthesis).
    10) Wigs (the first one following cancer treatment, not to exceed one per Benefit Period). See the Schedule of Cost-Shares and Benefits for any applicable dollar limits.

  Non-covered Prosthetic appliances include but are not limited to:

    1) Dentures, replacing teeth or structures directly supporting teeth;
    2) Dental appliances;

3) Such non-rigid appliances as elastic stockings, garter belts, arch supports and corsets;
4) Artificial heart implants;
5) Wigs (except as described above following cancer treatment.)
6) Penile prosthesis in men suffering impotency resulting from disease or injury.

If you have any questions regarding whether a specific prosthetic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Orthotic Devices -** Covered Services are the initial purchase, fitting, and repair of a custom made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part. The cost of casting, molding, fittings, and adjustments are included. Applicable tax, shipping, postage and handling charges are also covered. Applicable tax, shipping, postage and handling charges are also covered. The casting is covered when an orthotic appliance is billed with it, but not if billed separately.

  Covered orthotic devices include, but are not limited to, the following:

  1) Cervical collars.
  2) Ankle foot orthosis.
  3) Corsets (back and special surgical).
  4) Splints (extremity).
  5) Trusses and supports.
  6) Slings.
  7) Wristlets.
  8) Built-up shoe.
  9) Custom-made shoe inserts.

  Orthotic appliances may be replaced once per year per Member when Medically Necessary in the Member's situation. However, additional replacements will be allowed for Members under age 18 due to rapid growth, or for any Member when an appliance is damaged and cannot be repaired.

  Benefits for repairs and replacement do not include the following:

  1) Repair and replacement due to misuse, malicious breakage or gross neglect.
  2) Replacement of lost or stolen items.

  Coverage for an orthotic custom fabricated brace or support designed as a component for a prosthetic limb is described in more detail below.

  Non-covered items include but are not limited to:

  1) Orthopedic shoes;
  2) Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace;
  3) Standard elastic stockings, garter belts, and other supplies not specially made and fitted (except as specified under Medical Supplies);
  4) Garter belts or similar devices.

  If you have any questions regarding whether a specific orthotic is covered or want to obtain a detailed list, call the Customer Service number on the back of your Identification Card.

- **Prosthetic limbs & Orthotic custom fabricated brace or support -**

  Prosthetic limbs (artificial leg or arm) and a Medically Necessary orthotic custom fabricated brace or support designed as a component of a prosthetic limb, including repairs or replacements, will be covered if:

1) determined by your Physician to be Medically Necessary to restore or maintain your ability to perform activities of daily living or essential job related activities; and
2) not solely for comfort or convenience.

Coverage for Prosthetic limbs and orthotic devices under this provision must be equal to the coverage that is provided for the same device, repair, or replacement under the federal Medicare program. Reimbursement must be equal to the reimbursement that is provided for the same device, repair, or replacement under the federal Medicare reimbursement schedule, unless a different reimbursement rate is negotiated.

Prosthetic limbs and Orthotic custom fabricated braces or supports designed as a component for a prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject the same Deductible and/or Copayment provisions otherwise applicable under the Plan.

Outpatient Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Outpatient Services include facility, ancillary, facility use, and professional charges when rendered as an Outpatient at a Hospital, Alternative Care Facility, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and Therapy Services, surgery, or rehabilitation, or other Provider facility as determined by Us. Refer to the section titled “Behavioral Health Services” for services covered by the Plan. Professional charges only include services billed by a Physician or other professional.

For Emergency Accident or Medical Care refer to the **Emergency Care and Urgent Care** section.

Physician Home Visits and Office Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Covered Services include the care listed below when provided by a Physician in his or her office or your home. Refer to the sections titled “Preventive Care Services”, “Maternity Services”, and “Home Care Services”, for services covered by the Plan. For Emergency Care, refer to the “Emergency Care and Urgent Care” section.

- **Office visits** for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician’s office. Office visits also include, allergy testing, injections and serum. When allergy serum is the only charge from a Physician’s office, no Copayment is required. Coinsurance is not waived.
- **Home Visits** for medical care and consultations performed in your home to examine, diagnose, and treat an illness or injury.
- **Diagnostic Services** when required to diagnose or monitor a symptom, disease or condition.
- **Surgery and Surgical services** (including anesthesia and supplies). The surgical fee includes normal post-operative care.
- **Therapy Services** for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

After Hours Care

If you need care after normal business hours, your Doctor may have several options for you. You should call your Doctor’s office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Online Visits

When available in your area, your coverage will include online visit services. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions.

Prescription Drugs

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "tier" Drug. Refer to your Schedule of Cost-Shares and Benefits to determine your Copayment, Coinsurance and Deductible (if any) amounts. The determination of tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors. We retain the right, at Our discretion, to decide coverage for doses and administration (i.e., by mouth, shots, topical, or inhaled). We may cover one form of administration instead of another, or put other forms of administration in a different tier.

Note: Your Copayment(s) and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Anthem's designated Pharmacy Benefits Manager, from drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Anthem from Anthem's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List, (a Formulary), which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It is also based on the availability of over the counter medicines, Generic Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons.

If you have a question regarding whether a Drug is on the Prescription Drug Formulary, please call toll free 1-800-700-2533.

We retain the right, at Our discretion, to decide coverage for doses and administration methods (i.e., by mouth, shots, topical, or inhaled) and may cover one form of administration instead of another as Medically Necessary.

Your Contract limits Prescription Drug coverage to those Drugs listed on Our Prescription Drug List. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited Brand Name Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and you must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the PBM's Home Delivery Pharmacy;
- Specialty Drugs;
- Self-administered injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that need Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin;
- Self-administered contraceptives, including oral contraceptive Drugs, self-injectable contraceptive Drugs, contraceptive patches, and contraceptive rings; certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for more details.
- Flu Shots (including administration)

Where You Can Obtain Prescription Drugs

Your Contract includes benefits for Prescription Drugs you get at a Retail or Mail Order Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a (Mail Service) Pharmacy, and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

Retail

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the prescription from your Doctor and your Identification Card and they will file your claim for you. Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs. If you do not have your Identification Card, the Pharmacy will charge you the full retail price of the Prescription and will not be able to file the claim for you. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

> **Helpful tip:** Benefits for Prescription Drugs, including Specialty Drugs, which are administered to you in a medical setting (e.g., doctor's office, home care visit, or outpatient Facility) are covered under the "Administered by a Medical Provider" benefit. Please read that section for important details.

Your Mail Order Prescription Drug program is administered by Anthem's PBM which lets you get certain Drugs by mail if you take them on a regular basis (Maintenance Medication). Your mail order Prescriptions are filled by an independent, licensed Pharmacy. Anthem does not dispense Drugs or fill Prescriptions.

Refer to your Schedule of Cost-Shares and Benefits for any Copayment, Coinsurance, and/or Deductible that applies when you obtain Prescription Drugs.

> **Helpful Tip**: If you decide to use Mail Order, We suggest that you order your refill two weeks before you need it to avoid running out of your medication. For any questions concerning the mail order program, you can call customer service toll-free at 1-800-281-5524.

The Prescription must state the dosage and your name and address; it must be signed by your Physician.

The first mail order Prescription you submit must include a completed patient profile form. This form will be sent to you upon becoming eligible for this program. Any subsequent mail order Prescriptions for that Insured need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated mail order Prescription Drug program.

Note: Some Prescription Drugs and/or medicines are not available or are not covered for purchase through the mail order Prescription Drug program including, but not limited to, antibiotics, Drugs not on the Formulary, Drugs and medications to treat Infertility, impotence and/or sexual dysfunction, injectables,

including Self-Administered Injectables except Insulin. Please check with the mail order Prescription Drug program customer service department at 1-866-274-6825 for availability of the Drug or medication.

Specialty Pharmacy

Specialty drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. Specialty medications have special handling, storage and shipping requirements, such as temperature control. Specialty drugs may require nursing services or special programs to encourage patient compliance. Specialty Drugs are covered only when purchased from the Specialty Preferred Provider.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through the Specialty Preferred Provider

You can only have your Prescription for a Specialty Drug filled through the Anthem's Specialty Preferred Provider. Specialty Drugs are limited to a 30-day supply per fill. The Specialty Preferred Provider will deliver your specialty Drugs to you by mail or common carrier for self administration in your home. You cannot pick up your medication at Anthem.

The Prescription for the Specialty Drug must state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address and be signed by a Physician.

You or your physician may order your Specialty Drug from the Specialty Preferred Program by calling 1-800-870-6419. The PBM's Specialty Pharmacy has Dedicated Care Coordinators to help you take charge of your health problem and offers toll-free twenty-four hour access to nurses and pharmacists to answer your questions about Specialty Drugs. A Dedicated Care Coordinator will work with you and your Doctor to get Prior Authorization. When you call the Specialty Preferred Provider, a Dedicated Care Coordinator will guide you through the process up to and including actual delivery of your Specialty Drug to you. When you order your specialty drug by telephone, you will need to use a credit or debit card to pay for it. You may also submit your specialty drug prescription with the appropriate payment for the amount of the purchase and a properly completed order form to the Specialty Preferred Provider at the address shown below. Once you have met your Deductible, if any, you will only have to pay the cost of your Copayment or Coinsurance as found in the Schedule of Cost-Shares and Benefits. When you order your specialty drug by mail, you will need to use a check, money order, credit or debit card to pay for it.

You or your physician may obtain a list of specialty drugs available through the Specialty Preferred Provider network by contacting Member Services by calling toll free 1-800-870-6419 or online at www.anthem.com. You or your physician may also obtain order forms by contacting Member Services or by accessing Our web site at www.anthem.com.

Attn: Anthem Specialty Pharmacy Program
2825 Perimeter Road
Mail Stop – INRX01 A700
Indianapolis, IN 46241
Phone: (800) 870-6419
Fax: (800) 824-2642

Urgent or emergency need of a specialty drug subject to the Specialty Pharmacy Program

If you are out of a specialty drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the Specialty Pharmacy Program requirement for 72-hours, or until the next business day following a holiday or weekend to allow you to get a 72-hour emergency supply of medication, or the smallest packaged quantity, whichever is greater, if your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If you order your specialty drug through the Specialty Preferred Provider and it does not arrive, if your physician decides that it is Medically Necessary for you to have the drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a 30-day supply or less to allow you to get an emergency supply of medication from a Participating Pharmacy near you. A customer service representative from the Specialty Preferred Provider will coordinate the exception and you will not be required to pay additional Coinsurance.

Important Details About Prescription Drug Coverage

Your Contract includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, your prescribing Doctor may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process.

Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your Participating Pharmacist will be told of any rules when you fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for your health and safety. Certain Drugs may require Prior Authorization. Also, a Participating Pharmacist can help arrange Prior Authorization or dispense an emergency amount. If there are patterns of over utilization or misuse of Drugs, We will notify your personal Physician and your pharmacist. We reserve the right to limit benefits to prevent over utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact your Provider to get the details We need to decide if Prior Authorization should be given. We will give the results of Our decision to both you and your Provider.

If Prior Authorization is denied you have the right to file a Grievance as outlined in the “Member Grievances” section of this Contract.

For a list of Drugs that need Prior Authorization, please call the phone number on the back of your Identification Card or visit www.anthem.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under your Contract. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which Brand Name or Generic Drugs are covered under the Contract.

Step Therapy

Step therapy is a process in which you may need to use one type of Drug before We will cover another. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help you get high quality and cost effective Prescription Drugs. If a Doctor decides that a certain Drug is needed, the Prior Authorization will apply.

Administered by a Medical Provider

Your Contract also covers Prescription Drugs when they are administered to you as part of a doctor’s visit, home care visit, or at an outpatient Facility. This includes Drugs for infusion therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when your Provider orders the Drug and administers it to you. Benefits for Drugs that you inject or get at a Pharmacy (i.e., self-administered injectable Drugs) are not covered under this section. Benefits for those Drugs are described in the “Where You Can Obtain Prescription Drugs” section.

Helpful tip: When Prescription Drugs are covered under this benefit, they will not also be covered under the "Where You Can Obtain Prescription Drugs" benefit. Also, if Prescription Drugs are covered under the "Where You Can Obtain Prescription Drugs" benefit, they will not be covered under this benefit.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the "Schedule of Cost-Shares and Benefits." In most cases, you must use a certain amount of your prescription (e.g., 85%) before it can be refilled.

Half-Tablet Program

The Half-Tablet Program lets you pay a reduced Copayment on selected "once daily dosage" Drugs on Our approved list. The program lets you get a 30-day supply (15 tablets) of the higher strength Drug when the Doctor tells you to take a "½ tablet daily." The Half-Tablet Program is strictly voluntary and you should talk to your Doctor about the choice when it is available. To get a list of the Drugs in the program call the number on the back of your Identification Card.

Special Programs

From time to time We may offer programs to support the use of more cost-effective or clinically effective Prescription Drugs including Generic Drugs, Home Delivery Drugs, over the counter Drugs or preferred products. Such programs may reduce or waive Copayments or Coinsurance for a limited time. In addition, We may allow access to network rates for drugs not listed on Our Formulary.

Claims and Member Service

For information and assistance, a Member may call or write Anthem. The telephone number for Member Services is printed on the Member's Identification Card.

The address of Anthem is:

Anthem Blue Cross and Blue Shield
Member Services
220 Virginia Avenue
Indianapolis, IN 46204

Monday through Friday - 8:00 a.m. to 5:00 p.m.

Member Service Telephone

Toll Free In and Outside of Indiana – 1-(800) 477-4864
Pharmacy Benefits administered by Anthem Rx Network 1-(800) 662-0210
Home Office Address You may visit Our home office during normal business hours at:
220 Virginia Avenue, Indianapolis, IN 46204

Preventive Care Services

NOTE: Preventive Care Services in this section shall meet requirements as determined by federal and state law. Many preventive care services are covered by this Contract with no Deductible, Copayments or Coinsurance from the covered Member. That means Anthem pays 100% of the Maximum Allowed Amount. These services fall under four broad categories as shown below:

1) Services with an "A" or "B" rating from the United States Preventive Services Task Force. Examples of these services are screenings for:
    - Breast cancer;
    - Cervical cancer;
    - Colorectal cancer;
    - High blood pressure;

- Type 2 Diabetes Mellitus;
- Cholesterol;
- Child or Adult obesity.

2) Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3) Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4) Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:
    a) Women's contraceptives, sterilization procedures, and counseling. This includes Generic Drugs only, unless there is no Generic Drug equivalent, obtained from a Network pharmacy, as well as injectable contraceptives and patches. Contractive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. When Generic Drug equivalents are available, Prescription Brand Name contraceptives will not be covered under the Preventive Care benefit. Instead, Prescription contraceptives not covered under Preventive Care will be considered for benefits under the Prescription Drug benefit as described in the "Prescription Drugs" section.
    b) Breastfeeding support, supplies, and counseling. To obtain Network benefits, breast pumps and supplies must be received from Our Network Provider. If another Provider is used, benefits will be considered as Non-Network. Breast pumps are limited to one per pregnancy.
    c) Gestational diabetes screening.
    You may call Customer Service using the number on your ID card for additional information about these services.

In addition to the Federal requirements above, preventive coverage also includes the following Covered Services based on state law:

- Routine screening mammograms. Additional mammography views required for proper evaluation and any ultrasound services for Diagnostic screening of breast cancer, if determined Medically Necessary by your Physician, are also covered.
- Routine prostate specific antigen testing.
- Routine colorectal cancer examination and related laboratory tests. Examinations and tests will be covered more often as recommended by the current American Cancer Society guidelines or by your Physician.

Surgical Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Coverage for Surgical Services when provided as part of Physician Home Visits and Office Services, Inpatient Services, or Outpatient Services includes but is not limited to:

- Performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;
- Anesthesia (including services of a Certified Registered Nurse Anesthetist) and surgical assistance when Medically Necessary;
- Usual and related pre-operative and post-operative care;
- Cochlear implants;
- Other procedures as approved by Us.

The surgical fee includes normal post-operative care. We may combine the reimbursement when more than one surgery is performed during the same operative session. Contact Us for more information.

Covered Surgical Services include, but are not limited to:

- Operative and cutting procedures;
- Endoscopic examinations, such as arthroscopy, bronchoscopy, colonoscopy, laparascopy;
- Other invasive procedures such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine.

Reconstructive Services

Certain reconstructive services required to correct a deformity caused by disease, trauma, congenital anomalies, or previous therapeutic process are covered. Reconstructive services required due to prior therapeutic process are payable only if the original procedure would have been a Covered Service under this Plan. Covered Services are limited to the following:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child;
- Breast reconstruction resulting from a mastectomy. See "Mastectomy Notice" below for further coverage details;
- Hemangiomas, and port wine stains of the head and neck areas for children ages 18 years of age or younger;
- Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia;
- Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect;
- Tongue release for diagnosis of tongue-tied;
- Congenital disorders that cause skull deformity such as Crouzon's disease;
- Cleft lip;
- Cleft palate.

Mastectomy Notice

A Member who is receiving benefits for a mastectomy or for follow-up care in connection with a mastectomy, and who elects breast reconstruction, will receive coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the patient and the patient’s attending physician and will be subject to the same annual Deductible and/or Copayment provisions otherwise applicable under the Plan.

Sterilization

Regardless of Medical Necessity, you are covered for sterilization. Sterilizations for women will be covered under the “Preventive Care” benefit. Please see that section for further details.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures).

Therapy Services

See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

When Therapy Services are given as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, or Home Care Services, coverage for these Therapy Services is limited to the following:

Physical Medicine Therapy Services

The expectation must exist that the therapy will result in a practical improvement in the level of functioning within a reasonable period of time.

- **Physical therapy,** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non-Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.
- **Speech therapy** for the correction of a speech impairment.
- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). Non-Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptations to the home such as ramp ways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.
- **Manipulation Therapy** includes the manipulation and adjustment of the movable joint, muscle, and nerve tissue of the body to restore and maintain health and function.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment that may include the supportive use of an artificial kidney machine. If you require dialysis treatment and the

nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.

- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions that are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office, including but not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

A structured therapeutic program of an intensity that requires a multidisciplinary coordinated team approach to upgrade the patients ability to function as independently as possible; including skilled rehabilitative nursing care, physical therapy, occupational therapy, speech therapy and services of a social worker or psychologist. The goal is to obtain practical improvement in a reasonable length of time in the appropriate setting.

Physical medicine and rehabilitation involves several types of therapy, not just physical therapy, and a coordinated team approach. The variety and intensity of treatments required is the major differentiation from an admission primarily for physical therapy.

Non-Covered Services for physical medicine and rehabilitation include but are not limited to:

1) admission to a Hospital mainly for physical therapy;
2) long-term rehabilitation in an Inpatient setting.

Day Rehabilitation Program services provided through a Day Hospital for physical medicine and rehabilitation are Covered Services. A Day Rehabilitation Program is for those patients who do not require Inpatient care but still require a rehabilitation therapy program four (4) to eight (8) hours a day, two (2) or more days a week at a Day Hospital. Day rehabilitation program services may consist of Physical Therapy, Occupational Therapy, Speech Therapy, nursing services, and neuropsychological services. A minimum of two (2) Therapy Services must be provided for this program to be a Covered Service.

See the Schedule of Cost-Shares and Benefits for the limits on Therapy Services rendered on an Inpatient or Outpatient basis.

Transplant: Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services

This section describes benefits for certain Covered Transplant Procedures that you get during the Transplant Benefit Period. Any Covered Services related to a Covered Transplant Procedure, received before or after the Transplant Benefit Period, are covered under the regular Inpatient and Outpatient benefits described elsewhere in this Contract.

Covered Transplant Procedure

Any Medically Necessary human organ and stem cell / bone marrow transplants and infusions as determined by Us including necessary acquisition procedures, mobilization, harvest and storage, and including Medically Necessary myeloablative or reduced intensity preparative chemotherapy or radiation therapy or a combination of these therapies.

In-Network Transplant Provider

A Provider that Anthem has chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

The Provider has entered into a Transplant Provider Agreement to give Covered Transplant Procedures to you and take care of certain administrative duties for the transplant network. A Provider may be an in-Network Transplant Provider for:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Out-of-Network Transplant Provider

Any Provider that has **NOT** been chosen as a Center of Medical Excellence and/or a Provider selected to take part as an in-Network Transplant Provider by the Blue Cross and Blue Shield Association.

Unrelated Donor Searches

When approved by the Plan, your coverage includes benefits for unrelated donor searches for bone marrow/stem cell transplants performed by an authorized and licensed registry for a Covered Transplant Procedure.

Live Donor Health Services

Medically Necessary charges for the procurement of an organ from a live donor are covered up to the Maximum Allowable Amount, including complications from the donor procedure for up to six weeks from the date of procurement.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate / global time period. The number of days will vary depending on the type of transplant received and the in-Network Transplant Provider agreement. Contact the Case Manager for specific in-Network Transplant Provider information for services received at or coordinated by an in-Network Transplant Provider Facility. Services received from an out-of-Network Transplant Facility starts one day prior to a Covered Transplant Procedure and continues to the date of discharge.

Prior Approval and Precertification

In order to maximize your benefits, you will need to call Our Transplant Department to discuss benefit coverage when it is determined a transplant may be needed. **You must do this before you have an evaluation and/or work-up for a transplant.** Your evaluation and work-up services must be provided by an in-Network Transplant Provider to receive maximum benefits. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, in-Network Transplant Provider requirements, or exclusions are applicable. Contact the Customer Service telephone number on the back of your Identification Card and ask for the transplant coordinator. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

> **Helpful tip:** Receiving transplant evaluation and work-up services at an in-Network Transplant Facility will maximize your benefits.

Please note that there are instances where your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search services performed by an authorized registry and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

The Plan will provide assistance with reasonable and necessary travel expenses as determined by Us when you obtain prior approval and are required to travel more than 75 miles from your residence to reach the facility where your Transplant evaluation and /or Transplant work-up and Covered Transplant Procedure will be performed. Our assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. The Member must submit itemized receipts for transportation and lodging expenses in a form satisfactory to Us when claims are filed. Contact Us for detailed information.

For lodging and ground transportation benefits, We will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code.

Non-Covered Services for transportation and lodging include, but are not limited to:

- Meals,
- Child care,
- Mileage within the medical transplant facility city,
- Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us,
- Frequent Flyer miles,
- Coupons, Vouchers, or Travel tickets,
- Prepayments or deposits,
- Services for a condition that is not directly related, or a direct result, of the transplant,
- Telephone calls,
- Laundry,
- Postage,
- Entertainment,
- Travel expenses for donor companion/caregiver,
- Return visits for the donor for a treatment of a condition found during the evaluation.

The human organ and tissue transplant (bone marrow/stem cell) services benefits or requirements described above do not apply to the following:

- Cornea, ventricular assist devices, and
- Any Covered Services, related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. Please note that the initial evaluation and any necessary additional testing to determine your eligibility as a candidate for transplant by your Provider and the mobilization, harvest and storage of bone marrow / stem cells is included in the Covered Transplant Procedure benefit regardless of the date of service.

Covered Services received prior to or after the Transplant Benefit Period are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

> **Helpful tip:** See the Schedule of Cost-Shares and Benefits for any applicable Deductible, Coinsurance, Copayment, and Benefit Limitation information.

Pediatric Vision Services

Pediatric Eye Exam

This Plan covers a complete pediatric eye exam with dilation as needed. The exam is used to check all aspects of the vision, including the structure of the eyes and how well they work together.

Covered Vision Services are not subject to the calendar year Deductible or Out-of-Pocket Limit.

Eyeglass Lenses

There are choices in eyeglass lenses under this Plan. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic at no additional cost in Network.

Covered eyeglass lenses include up to 55mm in:

- single vision
- bifocal
- trifocal (FT 25-28)
- progressive

Frames (formulary)

A selection of frames is covered under this Plan. Members must choose a frame from the Anthem formulary.

Contact Lenses

Elective Contact Lenses
Elective contact lenses are contacts that are chosen for comfort or appearance.

Non-Elective Contact Lenses
Non-elective contacts are only provided for the following medical conditions:

- Keratoconus where the patient is not correctable to 20/40 in either or both eyes using standard spectacle lenses.
- High Ametropia exceeding -12D or +9D in spherical equivalent. Anisometropia of 3D or more.
- Patients whose vision can be corrected three lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

SPECIAL NOTE: We will not reimburse for non-elective contact lenses for any Member who has undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK.

NONCOVERED SERVICES/EXCLUSIONS

The following section indicates items that are excluded from benefit consideration, and are not considered Covered Services. We provide this information in order to help you identify certain common items that may be misconstrued as Covered Services. But this is not an all-inclusive list of items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary. For questions about whether a specific service or supply is a Covered Service, please call the Customer Service phone number on your ID card.

We do not provide benefits for procedures, equipment, services, supplies or charges:

1) Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, academic institution, or similar person or group.

2) Additional charges beyond the Maximum Allowable Amount for basic and primary services for services requested after normal Provider service hours or on holidays.

3) The following allergy tests and treatment:
    - IgE RAST tests unless intradermal tests are contraindicated.
    - Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
    - Food allergy test panels (including SAGE food allergy panels).
    - Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

4) For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.

5) For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared. At the Subscriber's request, We will refund any Premiums paid from the date the Member enters the military.

6) Related to artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.

7) For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this plan or any previous one of Our Plans, and it applies if the surgery was performed while the Member was covered by a previous carrier/self-funded plan prior to coverage under this Contract. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive

nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

8) For Behavioral Health Conditions which cannot be modified favorably according to accepted medical standards.

9) Removal or replacement of a breast implant that was initially done for augmentation or for cosmetic purposes. Reduction or augmentation mammoplasty is excluded unless associated with breast reconstruction surgery following a Medically Necessary mastectomy resulting from cancer.

10) Charges incurred after the termination date of this coverage.

11) Incurred prior to your Effective Date.

12) For cochlear implants, except as specified in the "Covered Services" section of this Contract.

13) Complications directly related to a service or treatment that is a non Covered Service under this Contract because it was determined by Us to be Experimental/Investigative or non Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigative or non Medically Necessary service and would not have taken place in the absence of the Experimental/Investigative or non Medically Necessary service.

14) For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

15) Provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric, psychological or social reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services, treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Member was covered by another carrier/self-funded plan prior to coverage under this Contract. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions. This exclusion also does not apply to plastic or reconstructive surgery to restore breast symmetry by reduction mammoplasty, mastopexy or breast augmentation as recommended by the oncologist or PCP for a Member incident to a covered mastectomy. Coverage will include reduction or uplift surgery on the unaffected breast to produce a symmetrical appearance.

16) Counseling Services and treatment related to religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy.

17) For court ordered testing or care, unless the service is Medically Necessary and authorized by Us.

18) We do not pay services, supplies, etc. for the following:
    - Custodial Care, convalescent care or rest cures.
    - Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
    - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary,

institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
- Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs.
- Wilderness camps.

The fact that the care or services described above have been recommended, provided, performed, prescribed, or approved by a Physician or other Provider will not establish that the care or services are Covered Services.

19) For Dental braces unless specifically stated as a Covered Service.

20) For Dental implants unless specifically stated as a Covered Service.

21) For dental treatment, regardless of origin or cause, except as specified as a Covered Service in this Contract. “Dental treatment” includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including but not limited to:
    - extraction, restoration and replacement of teeth.
    - medical or surgical treatments of dental conditions.
    - services to improve dental clinical outcomes.

22) For Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service . The only exceptions to this are for any of the following:
    - Transplant preparation.
    - Initiation of immunosuppressives.
    - Direct treatment of acute traumatic injury, cancer, or cleft palate.

23) For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.

24) For elective abortions and/or fetal reduction surgery. An elective (voluntary) abortion is one performed for reasons other than described in Maternity Services in the "Covered Services" section.

25) For admission as an Inpatient for environmental change.

26) For examinations relating to research screenings.

27) Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.

28) For prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.

29) Prescribed, ordered or referred by, or received from a member of your immediate family, including your spouse, child/stepchild, brother/stepbrother, sister/stepsister, parent/stepparent, in-law, or self.

30) For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.

31) For routine foot care (including the cutting or removal of corns and calluses); nail trimming, cutting or debriding; hygienic and preventive maintenance foot care, including but not limited to:
    - cleaning and soaking the feet.

- applying skin creams in order to maintain skin tone.
- other services that are performed when there is not a localized illness, injury or symptom involving the foot.

32) For completion of claim forms or charges for medical records or reports unless otherwise required by law.

33) To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.

34) For surgical treatment of gynecomastia.

35) For hearing exams, hearing aids or examinations for prescribing or fitting them, except as stated otherwise within this Contract.

36) Human Growth Hormone

37) For treatment of hyperhydrosis (excessive sweating).

38) For care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

39) For testing or treatment related to fertilization or infertility such as diagnostic tests performed to determine the reason for infertility and any service billed with an infertility related diagnosis..

40) For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.

41) For Manipulation Therapy services rendered in the home unless specifically stated as covered under the Home Care Services benefit.

42) In excess of Our Maximum Allowable Amounts.

43) Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.

44) Services and supplies for which you are eligible under Medicare, if you are a disabled Medicare beneficiary who does not have Current Employee Status. This Exclusion shall not apply to Dependents of a Subscriber who does have Current Employee Status.

45) For which benefits are payable under Medicare Parts A, B and/or D, or would have been payable if a Member had applied for Parts A, B, and/or D, except, as specified elsewhere in this Contract or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if the Member had enrolled; (2) for services or supplies provided pursuant to a private Contract between the Member and a Provider, for which reimbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

46) For missed or canceled appointments.

47) Any new FDA Approved Drug Product or Technology (including but not limited to medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to Pharmacies, for the first six months after the product or technology received FDA New Drug Approval or other applicable FDA approval. The Plan may at its sole discretion, waive this exclusion in whole or in part for a specific New FDA Approved Drug Product or Technology.

48) For which you have no legal obligation to pay in the absence of this or like coverage.

49) For mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by Us or specifically stated as a Covered Service.

50) For care received in an Emergency Room that is not Emergency Care, except as specified in this Contract. This includes, but is not limited to, suture removal in an Emergency Room.

51) For treatement of non-chemical addictions such as gambling, sexual, spending, shopping, working and religious.

52) For nutritional and dietary supplements, except as provided in the "Covered Services" section of this Contract or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either the written prescription or dispensing by a licensed pharmacist.

53) If benefits for that care are available to the Member under other medical or dental expense coverage. In that case, We pay the lesser of:
    a. the part of any Charge that is more than the other coverage's benefit or
    b. the benefit We would pay if You had no other coverage.

    Other medical or dental expense coverage includes, but is not limited to:
    a. individual or family plan health insurance;
    b. group health insurance
    c. automobile insurance

54) For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Contract or as required by law.

55) For personal hygiene, environmental control, or convenience items including but not limited to:
    - Air conditioners, humidifiers, air purifiers;
    - Health club membership, and physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas or similar facility.
    - Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
    - Charges from a health spa or similar facility;
    - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
    - Charges for non-medical self-care except as otherwise stated;
    - Purchase or rental of supplies for common household use, such as water purifiers;
    - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    - Infant helmets to treat positional plagiocephaly;
    - Safety helmets for Members with neuromuscular diseases; or

- Sports helmets.

56) Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes.

57) For health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

58) For stand-by charges of a Physician.

59) For Physician charges:
    - Physician or Other Practitioners' charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.
    - Surcharges for furnishing and/or receiving medical records and reports.
    - Charges for doing research with Providers not directly responsible for your care.
    - Charges that are not documented in Provider records.
    - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
    - For membership, administrative, or access fees charged by Physicians or other Providers.

    Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.

60) For services or supplies provided pursuant to a private contract between the Member and a Provider, for which reminbursement under the Medicare program is prohibited as specified in Section 1802 (42 U.S.C. 1395a) of Title XVII of the Social Security Act.

61) For Private Duty Nursing Services unless specifically stated in the Covered Services section.

62) Received from an individual or entity that is not a Provider, as defined in this Contract, or recognized by Us.

63) Reconstructive services except as specifically stated in the Covered Services section, or as required by law.

64) For services which are solely performed to prevent regression of functions for an illness, injury or condition which is resolved or stable.

65) For reversal of sterilization.

66) For a condition resulting from direct participation in a riot, civil disobedience, being intoxicated, influence of an illegal substance, nuclear explosion, nuclear accident or engaging in an illegal occupation.

67) Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

68) For self-help training and other forms of non-medical self care, except as otherwise provided herein.

69) Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.

70) Extracorporeal Shock Wave Treatment for plantar fasciitis and other musculoskeletal conditions.

71) For treatment of telangiectatic dermal veins (spider veins) by any method.

72) For Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

73) For treatment of alcoholism and/or Substance Abuse if you: fail to complete the treatment plan for a specific phase of treatment; are non-compliant with the treatment program; or are discharged against the medical advice of the attending Physician.

74) For medications used by an Outpatient to maintain drug addiction or drug dependency, or medications which are excessive or abusive for your condition or diagnosis.

75) For any services or supplies provided to a person not covered under the Contract in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

76) Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Contract or as required by law.

77) For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.

78) For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or specifically stated as a Covered Service.

79) For Temporomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures).

80) Services, supplies, and equipment for the following:
    - Gastric electrical stimulation.
    - Hypnotherapy.
    - Intestinal rehabilitation therapy.
    - Prolotherapy.
    - Recreational therapy.
    - Sensory integration therapy (SIT).

81) For any multiple Human Organ Transplant to the extent that the transplant also involves the transplantation of the stomach, and/or small intestine and/or colon.

82) For any type of Human Organ or Tissue Transplant not covered under this Contract or for any complications thereof.

83) For vision orthoptic training.

84) For any service for which you are responsible under the terms of this Contract to pay a Copayment, Coinsurance, or Deductible and the Copayment, Coinsurance or Deductible is waived by a Non-

Network Provider.

85) For weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Contract. This exclusion includes commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

86) For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.

87) Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non Covered Services for Ambulance include trips to:

- A Physician's office or clinic;
- A morgue or funeral home.

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician. Air ambulance services are not covered for transport to a Hospital that is not an acute care hospital, such as a nursing facility, physician's office, or your home.

88) Hospice Care exclusions - The following hospice services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services.
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition.
- Services not directly related to the medical care of the member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services.
- Services provided by volunteers.

89) EXPERIMENTAL/INVESTIGATIVE SERVICES EXCLUSION
Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be Experimental/Investigative is not covered under the Plan.

We will deem any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or

- is provided pursuant to informed consent documents that describe the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by Us. In determining whether a Service is Experimental/Investigative, We will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.
- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

We will identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

90) Provider Services you get from Providers that are not licensed by law to provide Covered Services, as defined in this Contract. Examples of such providers may include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

91) The following prescription drug services are not covered:
- Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).
- Clinically-Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined by Anthem to be Medically Necessary. In order for that Prescription Drug to be considered Medically Necessary, the Physician must substantiate

to Anthem, in writing, a statement that includes the reasons why use of that Prescription Drug is more medically beneficial than the clinically equivalent alternative.

- Compound Drugs
- Contrary to Approved Medical and Professional Standards: Drugs given to you or prescribed in a way that is against approved medical and professional standards of practice.
- Delivery Charges: Charges for delivery of Prescription Drugs.
- Drugs Given at the Provider's Office / Facility: Drugs you take at the time and place where you are given them or where the Prescription Order is issued. This includes samples given by a Doctor. This Exclusion does not apply to Drugs used with a diagnostic service, Drugs given during chemotherapy in the office as described in the "Therapy Services" section, or Drugs covered under the "Medical Supplies" benefit – they are Covered Services.
- Drugs That Do Not Need a Prescription: Drugs that do not need a prescription by federal law (including Drugs that need a prescription by state law, but not by federal law), except for injectable insulin.
- Drugs Over Quantity or Age Limits: Drugs in quantities which are over the limits set by Anthem, or which are over any age limits set by Us.
- Drugs Over the Quantity Prescribed or Refills After One Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one year after the date of the original Prescription Order.
- Items Covered as Durable Medical Equipment (DME): Therapeutic DME, devices and supplies except peak flow meters, spacers, blood glucose monitors.
- Items Covered as Medical Supplies: Oral immunizations and biologicals, even if they are federal Prescription Drugs, are covered as medical supplies based on where you get the service or item. Over the counter Drugs, devices or products, are not Covered Services.
- An allergenic extract or vaccine.
- Lost or Stolen Drugs: Refills of lost or stolen Drugs.
- Mail Service Programs other than the PBM's Home Delivery Mail Service: Prescription Drugs dispensed by any Mail Service program other than the PBM's Home Delivery Mail Service, unless We must cover them by law.
- Non-approved Drugs: Drugs not approved by the FDA.
- Off label use: Off label use, unless the PBM approves it, or when: (1) The Drug is recognized for treatment of the indication in at least one (1) standard reference compendium; (2) The Drug is recommended for that particular type of cancer and found to be safe and effective in formal clinical studies, the results of which have been published in a peer reviewed professional medical journal published in the United States or Great Britain.
- Onychomycosis Drugs: Drugs for Onychomycosis (toenail fungus) except when We allow it to treat Members who are immuno-compromised or diabetic.
- Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product. This includes Prescription Legend Drugs when any version or strength becomes available over the counter.
- Sex Change Drugs: Drugs for sex change surgery.
- Sexual Dysfunction Drugs: Drugs to treat sexual or erectile problems.
- Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.
- Weight Loss Drugs: Any Drug mainly used for weight loss.
- Drugs used for cosmetic purposes.
- Prescription Drugs used to treat infertility.

92) Your Vision care services do not include:

- Vision care for Members age 19 and older, unless covered by the medical benefits of this Contract.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if a Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this Contract or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a Network provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient hospital vision care, unless covered by the medical benefits of this Plan.
- For orthoptics or vision training and any associated supplemental testing.
- For two pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Plan.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- For services or supplies not specifically listed in this Plan.
- Cosmetic lenses or options.
- Blended lenses.
- Oversize lenses.
- Certain limitations on low vision.
- Optional cosmetic processes.
- For sunglasses.
- For services or supplies combined with any other offer, coupon or in-store advertisement.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.

93) Your Dental care services do not include services incurred for, or in connection with any of the items below:

- Dental care for Members age 19 and older.
- Dental services not listed as covered in this Contract.
- Oral hygiene instructions.
- Case presentations.
- Athletic mouth guards, enamel microabrasion and odontoplasty.

- Services or supplies that have the primary purpose of improving the appearance of your teeth. This includes but is not limited to tooth whitening agents or tooth bonding and veneer covering of the teeth.
- Placement or removal of sedative filling, base or liner used under a restoration when it is billed separately from a restoration procedure.
- Pulp vitality tests.
- Adjunctive diagnostic tests.
- Analgesia, analgesia agents, anxiolysis nitrous oxide, medicines, or drugs for non-surgical or surgical dental care.
- Retreatment or additional treatment necessary to correct or relieve the results of treatment previously covered under the Plan.
- Removal of pulpal debridement, pulp cap, post, pin(s), resorbable or non-resorbable filling material(s) and the procedures used to prepare and place material(s) in the canals (root).
- Root canal obstruction, internal root repair of perforation defects, incomplete endodontic treatment and bleaching of discolored teeth.
- Incomplete root canals.
- Bacteriologic tests for determination of periodontal disease or pathologic agents.
- The controlled release of therapeutic agents or biologic modifiers used to aid in soft tissue and osseous tissue regeneration.
- Provisional splinting, temporary procedures or interim stabilization.
- Services of anesthesiologists, unless required by law.
- Intravenous conscious sedation, IV sedation and general anesthesia when given separate from a covered complex surgical procedure.
- Anesthesia Services, except when given with covered complex surgical services and given by a dentist or by an employee of the dentist when the service is performed in his or her office who is certified in their profession to provide anesthesia services.
- Cytology sample collection - Collection of oral cytology sample via scraping of the oral mucosa.
- Dental services, appliances or restorations that are necessary to alter, restore or maintain occlusion, including but not limited to: increasing vertical dimension, replacing or stabilizing tooth structure lost by attrition, realignment of teeth, periodontal splinting and gnathologic recordings.
- Canal prep & fitting of preformed dowel & post.
- Temporary, provisional or interim crown.
- Occlusal procedures.
- Onlays or permanent crowns when the tooth does not have decay, fracture or has been endodontically treated.
- Pin retention is not covered when billed separately from restoration procedure.
- Services for the replacement of an existing partial denture with a bridge.
- Incomplete, interim or temporary services, including but not limited to fixed prosthetic appliances (dentures, partials or bridges).
- Additional, elective or enhanced prosthodontic procedures including but not limited to, connector bar(s), stress breakers and precision attachments.
- Separate services billed when they are an inherent component of another covered service.
- Cone beam images.
- Anatomical crown exposure.
- Temporary anchorage devices.
  Sinus augmentation.
- Repair or replacement of lost/broken appliances.

ELIGIBILITY AND ENROLLMENT

Eligibility

To be eligible for membership as a Subscriber under this Contract, the applicant must:

1) Be a United States citizen or national; or
2) Be a lawfully present non-citizen for the entire period for which coverage is sought; and
3) Be a legal resident of Indiana;
4) Be under age 65;
5) Submit proof satisfactory to Anthem to confirm Dependent eligibility;
6) Agree to pay for the cost of Premium that Anthem requires;
7) Be qualified as eligible, if applying to purchase a Catastrophic Plan;
8) Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
9) Not be incarcerated (except pending disposition of charges);
10) Not be entitled to or enrolled in Medicare Parts A/B and or D;
11) Not be covered by any other group or individual health benefit plan.

For purposes of Eligibility, the service area is the area in which you:

1) reside, intend to reside (including without a fixed address); or
2) the area in which you are seeking employment (whether or not currently employed); or
3) have entered without a job commitment.

Dependents

To be eligible for coverage to enroll as a Dependent, you must be listed on the enrollment form completed by the Subscriber, meet all Dependent eligibility criteria and be:

1) The Subscriber's legal spouse.

2) The Subscriber's Domestic Partner. Domestic Partner, or Domestic Partnership means a person of the same or opposite sex for whom all of the following are true: he or she is the Subscriber's sole Domestic Partner and has been for twelve (12) months or more; he or she is mentally competent; neither the Subscriber nor the Domestic Partner is related in any way (including by adoption or blood) that would prohibit him or her from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the Subscriber.

   For purposes of this Contract, a Domestic Partner shall be treated the same as a Spouse, and a Domestic Partner's Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child.

   A Domestic Partner's or a Domestic Partner's Child's Coverage ends at the end of the month of the date of dissolution of the Domestic Partnership.

   To apply for Coverage as Domestic Partners, both the Subscriber and the eligible Domestic Partner are required to complete and sign an Enrollment Application, meet all criteria stated in the Enrollment Application and submit the Enrollment Application to Anthem. We reserve the right to make the ultimate decision in determining eligibility of the Domestic Partner.

3) The Subscriber's or the Subscriber's spouse's children, including stepchildren, newborn and legally adopted children under age 26.

4) Children under age 26 for whom the Subscriber or the Subscriber's spouse is a legal guardian.

Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Plan must certify the Dependent's eligibility. The Plan must be informed of the Dependent's eligibility for continuation of coverage within 60 days after the date the Dependent would normally become ineligible. You must notify Anthem if the Dependent's tax exemption status changes and if he or she is no longer eligible for continued coverage.

The Plan may require the Subscriber to submit proof of continued eligibility for any enrolled child. Your failure to provide this information could result in termination of a child's coverage.

Temporary custody is not sufficient to establish eligibility under this Contract.

Any foster child who is eligible for benefits provided by any governmental program or law will not be eligible for coverage under this Contract unless required by the laws of this state.

Open Enrollment

An annual open enrollment period is provided for enrollees. Individuals may enroll in a plan, and Members may change plans at that time.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Member or an enrollee who experiences certain qualifying events or changes in eligibility may enroll in a plan, outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Member or enrollee has 60 calendar days from the date of a qualifying event to select a plan.

Qualifying Events:

- Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium
- Loss of Minimum Essential Coverage due to dissolution of marriage
- Marriage
- Adoption or placement for adoption; and
- Birth

Newborn and Adopted Child Coverage

Newborn children of the Subscriber or the Subscriber's spouse will be covered for an initial period of 31 days from the date of birth. Coverage for newborns will continue beyond the 31 days, provided the Subscriber with other than Family Coverage submits through the Plan a form to add the child under the Subscriber's Contract. The form must be submitted along with the additional Premium, if applicable, within 60 days after the birth of the child. Failure to notify the Plan and pay any applicable Premium during this 60 day period will result in no coverage for the newborn or adopted child beyond the first 31 days. A child will be considered adopted from the earlier of: (1) the moment of placement for adoption; or (2) the date of an entry of an order granting custody of the child to you. The child will continue to be considered adopted unless the child is removed from your home prior to issuance of a legal decree of adoption.

Adding a Child due to Award of Guardianship

If a Subscriber or the Subscriber's spouse files an application for an appointment of guardianship for a child, an application to cover the child under the Subscriber's Contract must be submitted to Us within 60 days of the date of the appointment of guardianship. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If you are required by a Qualified Medical Child Support Order or court order, as defined by applicable state or federal law, to enroll your child under this Contract, and the child is otherwise eligible for the coverage, We will permit your child to enroll under this Contract, and We will provide the benefits of this Contract in accordance with the applicable requirements of such order.

A child's coverage under this provision will not extend beyond the Dependent Age Limit. Any claims payable under this Contract will be paid, at Our discretion, to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective Date for the annual open enrollment period is the first day of the following Benefit Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable Premium payment.

Effective dates for Special Enrollment periods:

1) In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, or placement for adoption; and
2) In the case of marriage, or in the case where an Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after your application is received.

Effective dates for Special Enrollment due to loss of Minimum Essential Coverage apply when the loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1) Legal separation or divorce;
2) Cessation of Dependent status, such as attaining the maximum age;
3) Death of an employee;
4) Termination of employment;
5) Reduction in the number of hours of employment; or
6) Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    - Individual who no longer resides, lives or works in the Plan's Service Area,
    - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual,
    - Termination of employer contributions, and
    - Exhaustion of COBRA benefits.

There is no Special Enrollment for loss of Minimum Essential Coverage when the loss includes termination or loss due to:

Effective dates for loss of Minimum Essential Coverage does not include termination or loss due to:

1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or
2) Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible to notify Us of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Contract. We must be notified of any changes as soon as possible but no later than within 60 days of the event. This includes changes in address, marriage, divorce, death, change of Dependent disability or dependency status. Failure to notify Us of persons no longer eligible for services will not obligate Us to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

Family Coverage should be changed to Single Coverage when only the Subscriber is eligible. When notice is provided within 60 days of the event, the Effective Date of coverage is the event date causing

the change to Single Coverage. The Plan must be notified when a Member becomes eligible for Medicare.

All notifications must be in writing and on approved forms. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Plan applications or other forms or statements the Plan may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Plan is true, correct, and complete. Subscribers and applicants for membership understand that all rights to benefits under this Contract are subject to the condition that all such information is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by a Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card and a Contract for each Subscriber.

CHANGES IN COVERAGE: TERMINATION

This section describes how coverage for a Member can be cancelled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his/her coverage with appropriate notice to Anthem.
2. The Member no longer meets the eligibility requirements for coverage under this Contract.
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage.

Effective Dates of Termination

Except as otherwise provided, your coverage may terminate in the following situations. This information provided below is general, and the actual effective date of termination may vary based on your specific circumstances; for example, in no event will coverage be provided beyond the date Premium has been paid in full:

- If you terminate your coverage, termination will be effective on the last day of the billing period in which We receive your notice of termination.
- If the Member moves outside of the Service Area, or the Member is not located within the Service Area, coverage terminates for the Member and all covered Dependents at the end of the billing period that contains the date the Member failed to meet any of the conditions above regarding the Service Area.
- A Dependent's coverage will terminate at the end of the billing period in which notice was received by Us that the person no longer meets the definition of Dependent.
- If you permit the use of yours or any other Member's Plan Identification Card by any other person; use another person's card; or use an invalid card to obtain services, your coverage will terminate immediately upon Our written notice. Any Subscriber or Dependent involved in the misuse of a Plan Identification Card will be liable to and must reimburse Us for the Maximum Allowed Amount for services received through such misuse.
- If you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims, or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract, then We may terminate your coverage. Termination is effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.
- If you stop being an eligible Subscriber, or do not pay the required Premium, coverage terminates for all Members at the end of the period for which payment was made subject to the grace period.

IMPORTANT: Termination of the Contract automatically terminates all your coverage as of the date of termination, whether or not a specific condition was incurred prior to the termination date. Covered Services are eligible for payment only if your Contract is in effect at the time such services are provided.

Guaranteed Renewable

Coverage under this Contract is guaranteed renewable at the discretion of the Member, except as permitted to be canceled, rescinded, or not renewed under applicable state and federal law. The Member may renew this Contract by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1) Eligibility criteria continues to be met;

2) There are no fraudulent or intentional material misrepresentations on the application or under the terms of this coverage; and
3) Membership has not been terminated by Anthem under the terms of this Contract.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish any information requested regarding your eligibility and the eligibility of your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

Rescission

If within two (2) years after the Effective Date of this Contract, We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind this Contract as of the original Effective Date. Additionally, if within two (2) years after adding an additional Dependent (excluding newborn children of the Subscriber added within 31 days of birth), We discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material fact that you or your covered Dependents did not disclose on the application, We may terminate or rescind coverage for the additional covered Dependent as of his or her original Effective Date. We will give you at least 30 days written notice prior to rescission of this Contract

This Contract may also be terminated if you engage in fraudulent conduct, furnish Us fraudulent or misleading material information relating to claims or if you knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Contract. Termination will be effective 31 days after Our notice of termination is mailed. We will also terminate your Dependent's coverage, effective on the date your coverage is terminated.

You are responsible to pay Us for the cost of previously received services based on the Maximum Allowed Amount for such services, less any Copayment/Coinsurance made or Premium paid for such services. After the two (2) years following your Effective Date, We may only rescind or terminate your coverage on the basis of any act, practice or omission that constitutes fraud.

Discontinuation of Health Coverage

We can refuse to renew your Contract if We decide to discontinue a health coverage product that We offer in the individual market. If We discontinue a health coverage product, We will provide you with at least 90 days notice of the discontinuation. In addition, you will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Discontinuation will not affect an existing claim.

Cancellation

Once this Contract is cancelled, the former Members cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a special enrollment period prior to the annual open enrollment period.

Continuation of Coverage Under State Law

If We terminate this Contract, and you are hospitalized as an Inpatient for a medical or surgical condition on the date of termination, We will continue your coverage for Inpatient Covered Services. Coverage for Inpatient Covered Services will continue until the earliest of the following:

- The date you are discharged from the Hospital;
- Sixty (60) days after this Contract terminates;
- You obtain coverage from another carrier that is similar to or duplicates coverage provided by Us; or
- The Premium is not paid within the grace period shown in this Contract.

Grace Period

This Contract has a 31-day grace period. This means if any Premium except the first is not paid by its payment due date, it may be paid during the next 31 days. During the grace period, the Contract will stay in force and claims will be pended unless prior to the date Premium payment is due you give timely written notice to Us that the Contract is to be cancelled. If you do not make the full Premium payment during the grace period, the Contract will be cancelled on the last day through which Premium is paid. You will be liable to Us for the Premium payment due. You will be liable to Us for any claims payments made for services incurred after the date through which Premium is paid.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Plan. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Refund of Premium

Upon Termination, We shall return promptly the unearned portion of any Premium paid.

HOW TO OBTAIN COVERED SERVICES

In order to obtain benefits for covered services, care must be received care from Network Providers. Network Providers are the key to providing and coordinating your health care services. Contact a PCP, SCP, other Network Provider or Us to be sure that Prior Authorization and/or precertification has been obtained.

If you receive services from a Non-Network provider except in emergencies and out-of-area urgent care situations, you will be responsible for the charges for the services.

Service Area

The Service Area for this Plan is the State of Indiana.

Network Services and Benefits

If your care is rendered by a PCP, SCP, or another Network Provider, benefits will be provided at the Network level. Regardless of Medical Necessity, no benefits will be provided for care that is not a Covered Service even if performed by a PCP, SCP, or another network Provider. All medical care must be under the direction of Physicians. We have final authority to determine the Medical Necessity of the service or referral to be arranged.

We may inform you that it is not Medically Necessary for you to receive services or remain in a Hospital or other facility. This decision is made upon review of your condition and treatment. You may appeal this decision. See the "Member Grievances" section of this Contract.

- **Network Providers** include PCPs, SCPs, other professional Providers, Hospitals, and other facility Providers who contract with Us to perform services for you. PCPs include general practitioners, internists, family practitioners, pediatricians, obstetricians & gynecologists, geriatricians or other Network Providers as allowed by the Plan. The PCP is the Physician who may provide, coordinate, and arrange your health care services. SCPs are Network Physicians who provide specialty medical services not normally provided by a PCP.

  A consultation with a Network health care provider for a second opinion may be obtained at the same Copayment/Coinsurance as any other service.

  For services rendered by Network Providers:
  - **You will not be required to file any claims for services you obtain directly from** Network Providers. **Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Copayments/Coinsurance and/or Deductibles.** You may be billed by your Network Provider(s) for any non-Covered Services you receive or where you have not acted in accordance with this Contract.
  - **Health Care Management is the responsibility of the Network Provider.**

If there is no Network Provider who is qualified to perform the treatment you require, contact Us prior to receiving the service or treatment and We may approve a Non-Network Provider for that service as an Authorized Service. Non-Network Providers are described below.

Non-Network Services

Your health care plan does not cover benefits for services received from Non-Network providers unless the services are:

- To treat an Emergency Medical Condition;
- Out-of-area urgent care; or

- Authorized by Us.

Anthem has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking emergency services, urgent care services or other services authorized by Us in accordance with this Contract from Non-Network Providers could be balanced billed by the Non-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

How to Find a Provider in the Network

There are three ways you can find out if a Provider or Facility is in the network for this Plan. You can also find out where they are located and details about their license or training.

- See your Plan's directory of Network Providers at www.anthem.com, which lists the Doctors, Providers, and Facilities that participate in this Plan's network.
- Call Customer Service to ask for a list of Doctors and Providers that participate in this Plan's network, based on specialty and geographic area.
- Check with your Doctor or Provider.

If you need help choosing a Doctor who is right for you, call the Customer Service number on the back of your Member Identification Card. TTY/TDD services also are available by dialing 711. A special operator will get in touch with us to help with your needs.

First - Make an Office Visit with Your PCP

Your PCP's job is to help you stay healthy, not just treat you when you are sick. After you pick a PCP set up an office visit. During this visit, get to know your PCP and help your PCP get to know you. You should talk to your PCP about:

- Your personal health history,
- Your family health history,
- Your lifestyle,
- Any health concerns you have.

If you do not get to know your PCP, they may not be able to properly manage your care. To see a Doctor, call their office:

- Tell them you are an Anthem Member,
- Have your Member Identification Card handy. The Doctor's office may ask you for your group or Member ID number.
- Tell them the reason for your visit.

When you go to the office, be sure to bring your Member Identification Card with you.

If you need to see a Specialist, you can visit any Network Specialist including a behavioral health Provider. You do not have to get a referral.

If you have any questions about Covered Services, call Us at the telephone number listed on the back of your Identification Card.

Termination of Providers

You will be notified of the termination of PCP and/or Hospital Provider contracts in Our Service Area. If you are receiving care from a Network Provider whose contractual relationship with Us has terminated for a reason other than a quality of care issue, Indiana law allows you to request continued Covered Services from the terminated Network Provider for a set period.

Relationship of Parties (Plan – Network Providers)

The relationship between the Plan and Network Providers is an independent contractor relationship. Network Providers are not agents or employees of the Plan, nor is the Plan, or any employee of the Plan, an employee or agent of Network Providers.

The Plan shall not be responsible for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by a Member while receiving care from any Network Provider or in any Network Provider's facilities.

Your Network Provider's agreement for providing Covered Services may include financial incentives or risk sharing relationships related to provision of services or referrals to other Providers, including Network Providers, Non-Network Providers, and disease management programs. If you have questions regarding such incentives or risk sharing relationships, please contact your Provider or the Plan.

To be an informed consumer, it is important for you to know what services are covered under this Contract. At times, a Network Provider may recommend that you obtain services that are not covered under this Contract. If a Network Provider clearly informs you that We may not cover the services or continue to cover the services, and you agree with the Network Provider to continue the services solely at your expense, you will be held liable for the actual charges of all such non-Covered Services.

Not Liable For Provider Acts or Omissions

The Plan is not responsible for the actual care you receive from any person. This Contract does not give anyone any claim, right, or cause of action against the Plan based on the actions of a Provider of health care, services or supplies. We and Our Providers are independent entities contracting with each other for the sole purpose of carrying out the provisions of this Contract. We will not be liable for any act or omission of any Provider or any agent or employee of a Provider.

Network Physicians maintain the Physician-patient relationship with Members and are solely responsible to Members for all medical services they provide.

Identification Card

When you receive care, you must show your Identification Card. Only a Member who has paid the Premiums under this Contract has the right to services or benefits under this Contract. If anyone receives services or benefits to which he/she is not entitled to under the terms of this Contract, he/she is responsible for the actual cost of the services or benefits.

CLAIMS PAYMENT

How to Obtain Benefits

When your care is rendered by a Network Provider you are not required to file a claim. Since no claim filing is required, provisions below regarding “Claim Forms” and “Notice of Claim” do not apply.

How Benefits Are Paid

MAXIMUM ALLOWED (ALLOWABLE) AMOUNT (MAA)

GENERAL

Reimbursement for services rendered by Participating and Non-Participating Providers is based on the Maximum Allowed Amount for the Covered Service that you receive. Please see the “Inter-Plan Arrangements” section of this Contract for additional information.

The Maximum Allowed Amount is the maximum amount of reimbursement Anthem will allow for services and supplies:

- that meet Our definition of Covered Services, to the extent such services and supplies are covered under Your Contract and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable Prior Authorization, utilization management or other requirements set forth in your Contract.

You will be required to pay a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. In addition, when you receive Covered Services from a Non-Participating Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

Generally, services received from a Non-Network Provider under this Contract are not covered except for Emergency Care, or when allowed as a result of a Prior Authorization by Us. When you receive Covered Services from a Non-Network Provider, you may be responsible for paying any difference between the Maximum Allowed Amount and the Provider’s actual charges. This amount can be significant.

When you receive Covered Services from a Provider, We will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect Our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It only means We have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

When multiple procedures are performed on the same day by the same Provider, or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Participating Provider or a Non-Participating Provider.

A Participating Provider is a Provider who is in the managed network for this specific Contract or in a special center of excellence/or other closely managed specialty network. For Covered Services performed by a Participating Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with Anthem to accept as reimbursement for the Covered Services. Because Participating Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send you a bill or collect for amounts above the Maximum Allowed Amount. However, you may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent you have not met your Deductible or have a Copayment or Coinsurance. Please call Customer Service for help in finding a Participating Provider or visit Our website at www.anthem.com.

Providers who have not signed any contract with Us and are not in any of Our networks are Non-Participating Providers, subject to Blue Cross Blue Shield Association rules governing claims filed by certain ancillary providers.

For Covered Services you receive from a Non-Participating Provider that have been prior authorized by Us, the Maximum Allowed Amount for this Plan will be one of the following as determined by Anthem:

1) An amount based on Our Non-Participating Provider fee schedule/rate, which We have established in Our discretion, and which We reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts for like/similar Providers contracted with Anthem, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2) An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed amount upon the level or method of reimbursement used by CMS, Anthem will update such information, which is unadjusted for geographic locality, no less than annually; or
3) An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4) An amount negotiated by Us or a third party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management.
5) An amount based on or derived from the total charges billed by the Non-Participating Provider.

Providers who are not contracted for this product, but contracted for other products with Anthem are also considered Non-Participating. For this Plan, the Maximum Allowable Amount reimbursement for services from these Providers will be one of the five methods shown above unless the contract between Anthem and that Provider specifies a different amount.

Unlike Participating Providers, Non-Participating Providers may send you a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Participating Provider will likely result in lower out of pocket costs to you. Please call Customer Service for help in finding a Participating Provider or visit Anthem's website at www.anthem.com.

Customer Service is also available to assist you in determining this Plan's Maximum Allowed Amount for a particular service from a Non-Participating Provider. In order for Anthem to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Customer Service can assist you with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted.

For Prescription Drugs: The Maximum Allowed Amount for Prescription Drugs is the amount determined by Anthem using prescription drug cost information provided by the Pharmacy benefits manager (PBM).

MEMBER COST SHARE

For certain Covered Services and depending on your Contract, You may be required to pay a part of the Maximum Allowed Amount as your Cost-Share amount (for example, Deductible, Copayment, and/or Coinsurance).

Anthem will not provide any reimbursement for non-Covered Services. You will be responsible for the total amount billed by your Provider for non Covered Services, regardless of whether such services are performed by a Participating or Non-Participating Provider. Non-Covered Services include services specifically excluded from coverage by the terms of your Contract, and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, your day/visit limits

In some instances you may only be asked to pay the lower Network Cost-Sharing amount when you use a Non-Participating Provider. For example, if you go to a Participating Hospital or Provider Facility and receive Covered Services from a Non-Participating Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Participating Hospital or facility, you will pay the Participating cost share amounts for those Covered Services. However, you also may be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge.

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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Deductible Calculation

The Deductible applies to most Covered Services even those with a zero percent Coinsurance. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Copayments are not subject to and do not apply to the Deductible.

The Deductible and Copayment/Coinsurance amount incurred in a calendar year apply to the Out-of-Pocket Limit.

If this Plan covers the Subscriber (policyholder) only, the Subscriber must satisfy the Individual Deductible before payment will be made for most Covered Services. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

If this Plan covers 2 or more Members, the family members, collectively, must satisfy the Family Deductible before payment will be made for most Covered Services on any family member covered. An example of services not subject to the Deductible is Network Preventive Care Services required by law.

Out-of-Pocket Limit Calculation

The Deductible, Coinsurance, and Copayment amounts incurred in a calendar year apply to the Out-of-Pocket Limit.

Once the Out-of-Pocket Limit is satisfied, no additional Coinsurance will be required for the remainder of the calendar year.

[Optional Language]
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Authorized Services

In some non-Emergency circumstances, such as where there is no Participating Provider available for the Covered Service, We may Prior-Authorize the network Cost-Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from a Non-Participating Provider. In such circumstance, you must contact Anthem in advance of obtaining the Covered Service. We also will authorize the Participating Cost-Share amounts to apply to a claim for Covered Services if you receive Emergency services from a Non-Participating Provider and are not able to contact Anthem until after the covered service is rendered. If We authorize a Network cost share amount to apply to Covered Service received from a Non-Network/Non-Participating Provider, you may also still be liable for the difference between the Maximum Allowed Amount and the Non-Participating Provider's charge. Please contact Customer Service for Prior Authorized services information or to request authorization.

Example:

You require the services of a specialty Provider; but there is no Participating Provider for that specialty in your local Network area. You contact Anthem in advance of receiving any Covered Services, and We authorize You to go to an available Non-Participating Provider for that Covered Service and We agree that the Network Cost-Share will apply.

Your plan has a $25 Copayment for Participating Providers for the Covered Service. The Non-Participating Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because We have authorized the Participating Cost Share amount to apply in this situation, you will be responsible for the Participating Copayment of $25 and Anthem will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Non-Participating Provider's charge for this service is $500, You may receive a bill from the Non-Participating Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with Your Participating Copayment of $25, your total out of pocket expense would be $325.

Payment of Benefits

You authorize Us to make payments directly to Providers giving Covered Services for which We provide benefits under this Contract. We also reserve the right to make payments directly to you.

You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support order" as defined by applicable state law.

Once a Provider gives a Covered Service, We will not honor a request for Us to withhold payment of the claims submitted.

Assignment

Payments may not be assigned without Our written approval. The coverage and any benefits under this Contract are not assignable by any Member without the written consent of the Plan, except as described in this Contract.

Notice of Claim

We are not liable under the Contract, unless We receive written notice that Covered Services have been given to you.

The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the timeframes specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given.

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Claim Forms

Upon receipt of notice of claim, We will furnish you with the appropriate forms to file proof of loss. The form will be sent to you within 15 days after the receipt of such notice. If you do not receive the forms within 15 days, written notice of services rendered may be submitted to Us without the claim form.

Proof of Loss

Written proof of loss satisfactory to Us must be submitted to Us within 90 days after the date of the event for which claim is made. If proof of loss is not sent within the time required, the claim will not be reduced or denied if it was not possible to send proof within this time. However, the proof must be sent as soon as reasonably possible. In any case, the proof required must be sent to Us no later than one year following the 90 day period specified, unless you were legally incapacitated.

Many Providers may file for you. If your Provider will not file, and you do not receive a claim form from Us within 15 days of Our receipt of notice of claim, you may submit a written notice of services rendered to Us without the claim form. The same information that would be given on the claim form must be included in the written proof of loss. This includes:

- Name of patient
- Patient’s relationship with the Subscriber
- Identification number
- Date, type and place of service
- Your signature and the Physician’s signature

Time Benefits Payable

We will pay all benefits within 30 days for clean claims filed electronically, or 45 days for clean claims filed on paper. "Clean claim" means a claim submitted by you or a Provider that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. Generally, you will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We generally will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information.

If We fail to pay or deny a clean claim: (a) in 30 days for a claim filed electronically; or (b) in 45 days for a claim filed on paper, and We subsequently pay the claim, We will pay interest to the Provider that submitted the claim, as required under Indiana law.

At Our discretion, benefits will be paid to you or the Provider of services. You may not assign any payment. If other parties have paid benefits under this Plan, We may reimburse those other parties and be fully discharged from that portion of its liability.

Your Choice of Providers

- The choice of a Provider is solely yours.
- We do not furnish Covered Services but only pay for Covered Services you receive.
- We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

Member's Cooperation

Each Member shall complete and submit to the Plan such authorizations, consents, releases, assignments and other documents as may be requested by the Plan in order to obtain or assure reimbursement under Medicare, Worker's Compensation or any other governmental program. Any Member who fails to cooperate (including a Member who fails to enroll under Part B of the Medicare program where Medicare is the responsible payor) will be responsible for any charge for services.

Explanation of Benefits

After you receive medical care, you will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage you receive. The EOB is not a bill, but a statement from Us to help you understand the coverage you are receiving. The EOB shows:

- Total amounts charged for services/supplies received;
- The amount of the charges satisfied by your coverage;
- The amount for which you are responsible (if any);
- General information about your Appeals rights and for information regarding the right to bring an action after the Appeals process.

Inter-Plan Arrangements

Out-of-area services

Anthem covers only limited healthcare services received outside of Our Service Area. For example, emergency or urgent care obtained out of the Anthem Service Area is always covered.

For those out-of-area healthcare services that Anthem does cover, and which are obtained from Providers(s) that have a contractual agreement with a local Blue Cross and/or Blue Shield Licensee ("Host Blue") with which Anthem has a relationship (referred to as an "Inter-Plan Program"), a claim for those services may be processed through an Inter-Plan Program. If so, the claim will be presented to Anthem for payment in accordance with the then current rules that apply to these Programs. These Programs include the BlueCard® Program, which is described in general terms below.

BlueCard® Program

Under the BlueCard Program, when you obtain out-of-area covered services and supplies within the geographic area served by a Host Blue, Anthem will remain responsible for fulfilling its contractual obligations. But the Host Blue is responsible for: (a) contracting with its participating providers; and (b) handling interactions with those providers.

The BlueCard Program allows you to obtain out-of-area covered services and supplies from a healthcare provider participating with a Host Blue, where available. The participating provider will automatically file a claim for those covered services and supplies, so there are no claim forms to fill out. You are liable for the applicable copayment or coinsurance stated in this Evidence of Coverage.

Whenever you obtain covered services or supplies outside BCBS Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay for them, if not a Copayment, is calculated based on the lower of:

- The billed Covered Charges for the Covered Services or Supplies; or

- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with the Provider or Provider group that may include: types of settlements; incentive payments; and/or other credits or charges. Sometimes, it may be an average price, based on a discount that results in expected average savings for similar types of Providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. But such adjustments will not affect any price that Anthem has already paid for your claim or your liability for any such claim.

Also, federal law or laws in a small number of states may require the Host Blue to add a surcharge to a claim calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, Anthem would then calculate your liability for any Covered Service or Supply according to applicable law.

Non-Participating Healthcare Providers Outside Anthem's Service Area

As mentioned under "Out-of Area Services" above, Anthem only covers limited healthcare services outside of its Service Area. If you need to go to a non-participating, out-of-area Provider for emergency or urgent care, the charges for that care are covered. To the extent that the services of non-participating, out-of-area Providers are covered, the amount that you pay for the provided services, if not a Copayment, will generally be based on either the Host Blue's local payment to that Provider or any pricing arrangement required by applicable state law.

In some cases, Anthem may pay claims from non-participating Providers outside of Anthem's Service Area based on the Provider's billed charge. For example, this could happen in a case where you did not have reasonable access to a participating Provider, as determined by Anthem or in accordance with applicable state law. In other cases, Anthem may pay such a claim based on the payment We would make if We were paying a non-participating Provider inside of Our Service Area. This could happen when the Host Blue's payment for the service would be more than Our payment for the service. Also, at Our discretion, We may negotiate a payment with such a Provider on an exception basis.

Travel outside the United States – BlueCard Worldwide

If you plan to travel outside the United States, call customer service to find out if your plan has BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care

You can call the BlueCard WorldWide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177. An Assistance Coordinator will speak with you and help to set up an appointment with a doctor or hospital. The Assistance Coordinators will check with a medical professional, if needed, to determine the best course of action for you.

If you need inpatient hospital care, you or someone on your behalf, should contact Us for preauthorization. Keep in mind, if you need emergency medical care, go to the nearest hospital. There is no need to call before you receive care.

Please refer to the "Getting care in the right setting and how it affects preauthorization" paragraphs further in this section. You can learn how to get preauthorization when you need to be admitted to the hospital for emergency or non-emergency care.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange care with BlueCard Worldwide and receive services from a BlueCard Worldwide participating hospital, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms

You can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bcbs.com/bluecardworldwide.

You will find the address for mailing the claim on the form.

REQUESTING APPROVAL FOR BENEFITS

Your Plan includes the processes of Precertification, Predetermination and Post Service Clinical Claims Review to decide when services should be covered by your Plan. Their purpose is to aid the delivery of cost-effective health care by reviewing the use of treatments and, when proper, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be covered. When setting or place of service is part of the review, services that can be safely given to you in a lower cost setting will not be Medically Necessary if they are given in a higher cost setting.

Prior Authorization: Network Providers must obtain Prior Authorization in order for you to get benefits for certain services. Prior Authorization criteria will be based on many sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. Anthem may decide that a service that was prescribed or asked for is not Medically Necessary if you have not first tried other Medically Necessary and more cost effective treatments.

If you have any questions about the information in this section, you may call the Customer Service phone number on the back of your Identification Card.

Types of Requests

- **Precertification** – A required review of a service, treatment or admission for a benefit coverage determination which must be done before the service, treatment or admission start date. For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For labor / childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.

- **Predetermination** – An optional, voluntary Prospective or Continued Stay Review request for a benefit coverage determination for a service or treatment. We will check your Contract to find out if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Contract, or is Experimental/Investigative as that term is defined in this Contract.

- **Post Service Clinical Claims Review** – A Retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not need Precertification and did not have a Predetermination review performed. Medical Reviews are done for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Typically, Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Doctor will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, you may choose an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification

Services given by an Network Provider	Services given by a BlueCard/Non-Network/ Non-Participating Provider
Provider	Member has no benefit coverage for a Non-Network Provider unless: • You get authorization to use a Non-Network Provider before the service is given; or • For Emergency admissions, you, your authorized representative or Doctor must tell Us within 48 hours of the admission or as soon as possible within a reasonable period of time.

We will use Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, procedures, and preventative care clinical coverage guidelines, to help make Our Medical Necessity decisions, including decisions about Prescription and Specialty Drug services. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination, as decided solely by Us, notwithstanding that it might otherwise be found to be investigative as that term is defined in the Plan otherwise. Your Contract takes precedence over these guidelines.

You are entitled to ask for and get, free of charge, reasonable access to any records on which We based Our determination. To ask for this information, call the Precertification phone number on the back of your Identification Card.

Anthem may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Anthem's discretion, such change is in furtherance of the provision of cost effective, value based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt your claim from medical review if certain conditions apply.

Just because Anthem exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Anthem will do so in the future, or will do so in the future for any other Provider, claim or Insured. Anthem may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking your on-line Provider Directory on-line pre-certification list or contacting customer service at number on your identification card.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, then We may use one or more clinical utilization management guidelines in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to Plan's Members.

Request Categories

- **Emergent** – A request for Precertification or Predetermination that in the view of the treating Provider or any Doctor with knowledge of your medical condition, could without such care or treatment,

seriously threaten your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without such care or treatment.

- **Prospective** – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.

- **Continued Stay Review** - A request for Precertification or Predetermination that is conducted during the course of treatment or admission.

- **Retrospective** - A request for approval that is made after the service, treatment or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

Decision and Notice Requirements

We will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on state and federal laws. Where state laws are stricter than federal laws, We will follow state laws. If you live in and/or get services in a state other than the state where your Contract was issued, other state-specific requirements may apply. You may call the phone number on the back of your Identification Card for more details.

Request Category	**Timeframe Requirement for Decision and Notification**
Prospective Emergent	72 hours from the receipt of request
Prospective Non-Emergent	15 calendar days from the receipt of the request
Continued Stay Review when hospitalized at the time of the request	72 hours from the receipt of the request and prior to expiration of current certification.
Continued Stay Review Emergent when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Continued Stay Review Emergent when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Continued Stay Review Non-Emergent	15 calendar days from the receipt of the request
Retrospective	30 calendar days from the receipt of the request

If more information is needed to make Our decision, We will tell the requesting Provider and send written notice to you or your authorized representative of the specific information needed to finish the review. If We do not get the specific information We need or if the information is not complete by the timeframe identified in the written notice, We will make a decision based upon the information We have.

We will give notice of Our decision as required by state and federal law. Notice may be given by the following methods:

Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.

Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and you or your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date you get service:

1) You must be eligible for benefits;
2) Premium must be paid for the time period that services are given;
3) The service or supply must be a covered benefit under your Plan;
4) The service cannot be subject to an Exclusion under your Plan; and
5) You must not have exceeded any applicable limits under your Plan.

Health Plan Individual Case Management

Our health plan Case Management programs help coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management Program to help meet their health-related needs.

Our Case Management programs are confidential and voluntary and are made available at no extra cost to you. These programs are provided by, or on behalf of and at the request of, your health plan case management staff. These Case Management programs are separate from any Covered Services you are receiving.

If you meet program criteria and agree to take part, we will help you meet your identified health care needs. This is reached through contact and team work with you and/or your chosen representative, treating Doctor(s), and other Providers

In addition, We may assist in coordinating care with existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care that is not listed as a Covered Service through Our Case Management program. We may also extend Covered Services beyond the Benefit Maximums of this Plan. We will make Our decision case-by-case, if in Our discretion the alternate or extended benefit is in the best interest of the Member and Anthem. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to you or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify you or your representative in writing.

MEMBER GRIEVANCES

Grievances

If you are dissatisfied with medical treatment you have received, you should discuss the problem with your Provider. If the problem is not resolved at that level, or if the dissatisfaction concerns another matter, you should contact Us, either orally or in writing to obtain information on our Grievance procedures or to file a Grievance with Us.

You have the right to designate a representative (e.g. your Physician) to file a Grievance and, if the Grievance decision is adverse to you, an Appeal, with Us on your behalf and to represent you in a Grievance or an Appeal. If a Provider files a Grievance with Us that qualifies for Expedited Review, the Provider will be deemed to be your representative and correspondence concerning the Grievance will be sent directly to the Provider. In all other situations in which a representative seeks a Grievance or an Appeal on your behalf, We must obtain a signed Designation of Representation form from you before We can deal directly with your representative. We will forward a Designation of Representation form to you for completion. If We do not obtain a signed Designation of Representation form, We will continue to research your Grievance but will respond only to you unless a Designation of Representation form is received.

We will accept oral or written comments, documents or other information relating to the Grievance from the Member or the Member's Provider by telephone, facsimile or other reasonable means. Members are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Member's Appeal.

To obtain information on Our Grievance procedures or to file a Grievance orally with Us, please call the toll free customer service number listed on the back of your Plan Identification Card. A Plan representative who is knowledgeable about Our Grievance procedures and any applicable state laws and regulations will be available to assist you at least 40 normal business hours per week.

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative.

We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, please mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 3 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but no later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

If your Grievance cannot be resolved within 20 business days due to Our need for additional information and your Grievance is not related to an adverse certification decision (i.e. Prospective, Concurrent or Retrospective review decision) or the denial of any other Prior Authorization required by the Plan, you will be notified in writing of a 10 business day extension. This notice for an extension will be sent to you on or before the 19th business day. The extension may occur when the information is requested from a Provider, or from you, and such information has not been received within 15 business days from Our original request. In the event of an extension, We will resolve the Grievance within 30 business days from the date you filed the Grievance. If the requested information has not been received, We will make a determination based on the information in Our possession.

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member.

Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

If Our decision under the Grievance process is satisfactory to you, the matter is concluded. If Our decision is not satisfactory, you or your designated representative may initiate an Appeal by contacting the Plan either in writing or by phone at the above address and phone numbers. You will receive an acknowledgment of your Appeal within 5 business days of Our receipt of your Appeal request. Our acknowledgment may be oral for those Appeals We receive orally. We will set a date and time during normal business hours for Our Appeal panel members to meet to discuss your Appeal. You or your representative do not have to be present when the panel meets; however you or your representative may appear in person or by telephone conference to communicate with the Appeal panel if desired. You or your representative may submit oral or written comments, documents or other information relating to the Appeal for consideration by the Appeal panel whether or not you choose to appear in person or by telephone. You will be given at least 72 hours advance notice of the date and time of the panel meeting. Appeals concerning adverse Precertification, Concurrent Review or Case Management decisions will be resolved by the panel no later than 30 calendar days from the date your Appeal request was received by Us. The panel will resolve all other Appeals no later than 45 business days from the date your Appeal request was received by Us. After the Appeal panel makes a decision, you will be notified within 5 business days in writing by Us of Our decision concerning your Appeal.

Expedited Review

Expedited Review of a Grievance or Appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available if all of the following are met:

- The service at issue has not been performed;
- Your physician believes that the standard Appeal time frames could seriously jeopardize your life or health or could subject you to severe pain that cannot be adequately managed.

We will complete Expedited Review of a Grievance as soon as possible given the medical exigencies but no later than within forty-eight hours (48 hours) of Our receipt of sufficient information and will communicate Our decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and the facility rendering the service. We will complete Expedited Review of an Appeal as expeditiously as the medical condition requires and Panel administration permits. Our decision will be communicated by telephone to your attending Physician or the ordering Provider. We will also provide written notice of Our determination to you, your attending physician or ordering provider, and to the facility rendering the service.

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External Grievance

If Our decision under the Appeals process is not satisfactory to you, you may qualify to request an External Grievance. To qualify for an External Grievance all of the following requirements must be met:

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse utilization review determination; or

- an adverse determination of Medical Necessity; or
- a determination that a proposed service is Experimental/Investigational; or

2. Your Appeal is regarding Our decision to rescind coverage under this Contract; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after you are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Contract.

If an External Grievance is requested, We will forward the Grievance along with all relevant information to an independent review organization. The independent review organization will make a determination to uphold or reverse Our Appeal determination within 3 business days if an urgent condition exists which would qualify for Expedited Review or within 15 business days if the condition is non-urgent. The independent review organization will notify you and Us of its determination within 24 hours if an urgent condition exists which would qualify for Expedited Review or within 72 hours if the condition is non-urgent. If the independent review organization's determination is to reverse Our Appeals decision, We will notify you or your Provider in writing of the steps We will be taking to comply with the determination.

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is not received by Us within 180 calendar days of the date you are notified of an adverse decision. We will accept Appeals filed within 120 days from the date you receive notice of the decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with Us you may contact the Department of Insurance by mail, telephone or e-mail:

State of Indiana Department of Insurance
Consumer Services Division
311 W. Washington Street, Suite 300,
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.ingov/idoi

For Dental:

Please submit appeals regarding your dental coverage to the following address:

Anthem

PO Box 1122

Minneapolis, MN 55440-1122

For Blue View Vision:

For questions or concerns about your vision benefits that you are unable to resolve with Vision Customer Service at 1-866-723-0515, and for which you wish to file a Grievance, please direct your Grievance to:

Anthem Blue Cross and Blue Shield / Blue View Vision

Attn: Grievance Department

555 Middle Creek Parkway

Colorado Springs, CO 80921

[Optional Language]

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GENERAL PROVISIONS

Entire Contract

This Contract, the application, any Riders, Endorsements or Amendments, constitute the entire Contract between the Plan and you and as of the Effective Date, supersede all other agreements between the parties. Any and all statements made to the Plan by you and any and all statements made to you by the Plan are representations and not warranties, and no such statement, unless it is contained in a written application for coverage under this Contract, shall be used in defense to a claim under this Contract.

Entire Contract Changes

No change in this Contract shall be effective until approved in writing by one of Our executive officers. No agent has the authority to change or waive any of this Contract's provisions. We are not bound by any verbal promises made by any of Our executive officers, employees or agents.

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that the Provider is responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment by Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the physician-patient relationship and as obstructing the provision of proper medical care. Providers shall use their best efforts to render all Medically Necessary and appropriate health care services in a manner compatible with your wishes, insofar as this can be done consistently with the Provider's judgment as to the requirements of proper medical practice.

If you refuse to follow a recommended treatment or procedure, and the Provider believes that no professionally acceptable alternative exists, you will be so advised. In such case, neither the Plan, nor any Provider shall have any further responsibility to provide care in the case of the Provider, and to arrange care in the case of the Plan for the condition under treatment or any complications thereof.

Circumstances Beyond the Control of the Plan

In the event of circumstances not within the control of the Plan, including but not limited to, a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil, insurrection, disability of a significant part of a Network Provider's personnel or similar causes, or the rendering of health care services provided under this Contract is delayed or rendered impractical, the Plan shall make a good-faith effort to arrange for an alternative method of providing coverage. In such event, the Plan and Network Providers shall render health care services provided under this Contract insofar as practical, and according to their best judgment; but the Plan and Network Providers shall incur no liability or obligation for delay, or failure to provide or arrange for services if such failure or delay is caused by such an event.

Worker's Compensation

The benefits under this Contract are not designed to duplicate any benefit for which Members are eligible under the Worker's Compensation Law. All sums paid or payable by Worker's Compensation for services provided to Members shall be reimbursed by, or on behalf of, the Member to the Plan to the extent the Plan has made or makes payment for such services. It is understood that coverage hereunder is not in lieu of, and shall not affect, any requirements for coverage under Worker's Compensation.

Medicare

Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers Medicare and Medicaid Services guidelines, subject to federal

court decisions. Federal law controls whenever there is a conflict among State law, Contract provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Contract for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B and/or D. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits under this Plan, if the Member has not enrolled in Medicare Parts B & D, We will calculate benefits as if they had enrolled.

Coordination Of Benefits

This Coordination of Benefits (COB) provision applies when you have health care coverage under more than one Plan.

Please note that several terms specific to this provision are listed below. Some of these terms have different meanings in other parts of the Contract, e.g., Plan. For this provision only, "Plan" will have the meanings as specified in the below. In the rest of the Contract, Plan has the meaning listed in the **Definitions** section.

The order of benefit determination rules determines the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits according to its policy terms regardless of the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

The Allowable expense under COB is generally the higher of the Primary and Secondary Plans' allowable amounts. A Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher of the Plans' allowable amounts. This higher allowable amount may be more than our Maximum Allowable Amount.

COB DEFINITIONS

Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1) Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicare, Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.
2) Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

Each contract for coverage under items 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

This Plan means the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determines whether This Plan is a Primary Plan or Secondary Plan when you have health care coverage under more than one Plan.

When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering you. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering you is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging you is not an Allowable expense; however, if a Provider has a contractual agreement with both the Primary and Secondary Plans, then the higher of the of the contracted fees is the Allowable expense, and the Provider may charge up to the higher contracted fee.

The following are non Allowable expenses:

3) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
4) If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
5) If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
6) If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.
7) The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.
8) The amount that is subject to the Primary high-deductible health plan’s deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.
9) Any amounts incurred or claims made under the Prescription Drug program of This Plan.

Closed panel plan is a Plan that provides health care benefits primarily in the form of services through a panel of Providers that contract with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When you are covered by two or more Plans, the rules for determining the order of benefit payments are:

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

1) Except as provided in Paragraph 2. below, a Plan that does not contain a coordination of benefits provision that is consistent with this COB provision is always primary unless the provisions of both Plans state that the complying Plan is primary.
2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage will be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are placed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide Non-Network benefits.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Each Plan determines its order of benefits using the first of the following rules that apply:

Rule 1 - Non-Dependent or Dependent. The Plan that covers you other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan, and the Plan that covers you as a Dependent is the Secondary Plan. However, if you are a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering you as a Dependent and primary to the Plan covering you as other than a Dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering you as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan covering you as a Dependent is the Primary Plan.

Rule 2 - Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

1) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
    - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
    - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
    - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
    - If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
    - If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
    - If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
        - The Plan covering the Custodial parent;
        - The Plan covering the spouse of the Custodial parent;
        - The Plan covering the non-custodial parent; and then

— The Plan covering the spouse of the non-custodial parent.

3) For a Dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of item 1. above will determine the order of benefits as if those individuals were the parents of the child.

Rule 3 - Active Employee or Retired or Laid-off Employee. The Plan that covers you as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Plan. The Plan also covering you as a retired or laid-off employee is the Secondary Plan. The same would hold true if you are a Dependent of an active employee and you are a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 4 - COBRA or State Continuation Coverage. If you are covered under COBRA or under a right of continuation provided by State or other federal law and are covered under another Plan, the Plan covering you as an employee, member, subscriber or retiree or covering you as a Dependent of an employee, member, subscriber or retiree is the Primary Plan and the COBRA or State or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if "Rule 1 - Non-Dependent or Dependent" can determine the order of benefits.

Rule 5 - Longer or Shorter Length of Coverage. The Plan that covered you longer is the Primary Plan and the Plan that covered you the shorter period of time is the Secondary Plan.

Rule 6. If the preceding rules do not determine the order of benefits, the Allowable expenses will be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim.

Because the Allowable expense is generally the higher of the Primary and Secondary Plans' allowable amounts, a Network Provider can bill you for any remaining Coinsurance, Deductible and/or Copayment under the higher allowable amount. In addition, the Secondary Plan will credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If you are enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB will not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts We need from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Us is more than should have paid under this COB provision, We may recover the excess from one or more of the persons:

1) We have paid or for whom We have paid; or
2) Any other person or organization that may be responsible for the benefits or services provided for the Member.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Subrogation and Reimbursement

These provisions apply when We pay benefits as a result of injuries or illness you sustained and you have a right to a Recovery or have received a Recovery.

Subrogation

We have the right to recover payments We make on your behalf from any party responsible for compensating you for your injuries. The following apply:

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

If you obtain a Recovery and We have not been repaid for the benefits We paid on your behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following apply:

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. You must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered

by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

- If you fail to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your Recovery whichever is less, from any future benefit under the Plan if:

    1. The amount We paid on your behalf is not repaid or otherwise recovered by Us; or
    2. you fail to cooperate.

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and We would not have any obligation to pay the provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

- You must notify Us promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.
- You must cooperate with Us in the investigation, settlement and protection of Our rights.
- You must not do anything to prejudice Our rights.
- You must send Us copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.
- You must promptly notify Us if you retain an attorney or if a lawsuit is filed on your behalf

Interpretation of Contract

The laws of the State in which the Contract is issued shall be applied to the interpretations of this Contract.

Conformity with Law

Any provision of this Plan which is in conflict with the laws of the State in which the Contract is issued, or with federal law, is hereby automatically amended to conform with the minimum requirements of such laws.

Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from you or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide you with notice of overpayments made by Us or you if the recovery method makes providing such notice administratively burdensome.

Legal Action

You may not take legal action against Us to receive benefits:

- Earlier than 60 days after We receive the claim; or
- Later than three years after the date the claim is required to be furnished to Us.

You must exhaust the Plan's Member Grievance and Appeal procedures before filing a lawsuit or other legal action of any kind against Us.

Misstatement of Age

If a Member's age has been misstated, We will adjust the premiums and/or benefits under this Contract. The benefits will be the amount the premiums paid would have purchased at the correct age and/or sex.

Premium

You shall have the responsibility for remitting payments to Anthem as they come due. Even if you have not received a premium notice from Anthem, you are still obligated to pay, at a minimum, the amount of the prior premium notice.

An administrative fee of $[20] will be charged for any check, automatic deduction, or Electronic Funds Transfer which is returned or dishonored by the financial institution as non-payable to Anthem for any reason.

The amount of premium is printed on your premium notice; however, this amount is subject to change. We will not increase premium for any reason without giving you at least 30 days written notice. We will then send you a new notice with the new premium amount.

If a premium increase is necessary, We will bill you for the extra amount due. If this amount is not paid, this Contract will be canceled at the end of the Grace Period and you will receive a refund of any unearned premium.

If a decrease in premium is appropriate, We will adjust what is owed to Us and let you know the new amount of premium due. We will refund any excess premium to you.

If We have not charged the proper amount of premium, We will let you know the new amount of premium due from you. We will refund any amount which has been overpaid to Us. You must pay Us any amounts which should have been paid but were not.

If premium has been paid for any period of time after the date you cancel this Contract, We will refund that premium to you. The refund will be for that period of time after your coverage ends. Also, if a Member dies while this Contract is in force, We will refund the premium paid for such Member for any period after the date of the Member's death to you or your estate.

Changes in Premiums

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The Premium for this Contract may change subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records 30 days in advance. Any such change will

apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

[Optional Language]

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Unpaid Premium

Upon the payment of a claim under this Contract, any premium then due and unpaid or covered by any note or written order may be deducted there from.

Provider Reimbursement

Benefits shown in this Contract or the Schedule of Benefits for Covered Services may vary depending on whether the Provider has a reimbursement agreement with Us.

Providers who have a reimbursement agreement with Us have agreed to accept either our Maximum Allowable Amount or a negotiated amount as payment in full.

Providers who do not have a reimbursement agreement with Us will normally bill you for amounts we consider to exceed the Maximum Allowable Amount in addition to any Deductibles and/or Copayments.

Regardless of whether the Provider has a reimbursement agreement with Us, your payment obligations for Deductibles and/or Copayment amounts are always determined using the Maximum Allowable Amount.

Benefit amounts applied to your payment maximum mean the amounts actually paid by Us for services received from a Provider which does not have a reimbursement agreement with Us or the amount for which you are given credit by a Provider which has a reimbursement agreement with Us.

Policies and Procedures

The Plan may adopt reasonable policies, procedures, rules and interpretations to promote the orderly and efficient administration of this Contract with which a Member shall comply.

Waiver

No agent or other person, except an authorized officer of the Plan, has authority to waive any conditions or restrictions of this Contract, to extend the time for making a payment to the Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, at its sole discretion, cover services and supplies not specifically covered by the Contract. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies which would otherwise be required for the care and treatment of a Member.

Severability

In the event that any provision in this Contract is declared legally invalid by a court of law, such provision will be severable and all other provisions of the Contract will remain in force and effect.

Anthem Insurance Companies, Inc. Note

The Subscriber hereby expressly acknowledges its understanding this Contract constitutes a contract solely between the Subscriber and Anthem Insurance Companies, Inc. (Anthem), which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an

association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Anthem to use Blue Cross and/or Blue Shield Service Marks in the State of Indiana, and that Anthem is not contracting as the agent of the Association. The Subscriber further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem), and that no person, entity, or organization other than Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) shall be held accountable or liable to the Subscriber for any of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield's (Anthem's) obligations to the Subscriber created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield (Anthem) other than those obligations created under other provisions of this agreement.

Voluntary Clinical Quality Programs

We may offer additional opportunities to assist you in obtaining certain covered preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that you have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage you to get certain care when you need it and are separate from Covered Services under your Contract. These programs are not guaranteed and could be discontinued at any time. We will give you the choice and if you choose to participate in one of these programs, and obtain the recommended care within the program's timeframe, you may receive incentives such as gift cards. Under other clinical quality programs, you may receive a home test kit that allows you to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If you receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to you. For additional guidance, please consult your tax advisor.)

Medical Policy and Technology Assessment

Anthem reviews and evaluates new technology according to its technology evaluation criteria developed by its medical directors. Technology assessment criteria are used to determine the Experimental/ Investigative status or Medical Necessity of new technology. Guidance and external validation of Anthem's medical policy is provided by the Medical Policy and Technology Assessment Committee (MPTAC) which consists of approximately 20 Doctors from various medical specialties including Anthem's medical directors, Doctors in academic medicine and Doctors in private practice.

Conclusions made are incorporated into medical policy used to establish decision protocols for particular diseases or treatments and applied to Medical Necessity criteria used to determine whether a procedure, service, supply or equipment is covered.

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Value-Added and Incentive Programs

We may offer health or fitness related programs and products to Our Members, through which you may access discounted rates from certain vendors for products and services available to the general public. We may also offer value-added services that include discounts on pharmacy products (over the counter drugs, consultations and biometrics).

In addition, you may have access to additional value-added services that include discounts on pet medications, wholesale club memberships, mobile phone minutes and banking and payment services.

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under your Contract and could be discontinued at any time. We do not

endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services you receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

[Optional Language]

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DEFINITIONS

This section defines terms which have special meanings. If a word or phrase has a special meaning or is a title, it will be capitalized. The word or phrase is defined in this section or at the place in the text where it is used.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service - A Covered Service rendered by any Provider other than a Network Provider which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Copayment/Coinsurance and Deductible.

Behavioral Health Conditions – See Mental Health and Substance Abuse definition.

Benefit Period – The period of time that We pay benefits for Covered Services. The Benefit Period is a calendar year for this Plan, as listed in the Schedule of Cost-Shares and Benefits. If your coverage ends earlier, the Benefit Period ends at the same time.

Benefit Period Maximum – The maximum We pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The term Brand Name Drug means Prescription Drugs that the PBM has classified as Brand Name Drugs through use of an independent proprietary industry database.

Clinical Trial - The term Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life-threatening chronic disease in human beings.

Coinsurance - Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. Your Coinsurance will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Contract – The contract between Us and the Subscriber. It includes this Contract, your Schedule of Cost-Shares and Benefits, your application, any supplemental application or change form, your Identification Card, and any endorsements or riders.

Copayment - A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service. The Copayment does not apply to any Deductible.

Cost-Share - The term Cost-Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance, and/or Deductibles.

Covered Services – Services, supplies or treatment as described in this Contract which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Contract.
- Within the scope of the license of the Provider performing the service;
- Rendered while coverage under this Contract is in force;
- Not Experimental/Investigative or otherwise excluded or limited by this Contract, or by any amendment or rider thereto.

- Authorized in advance by Us if such Prior Authorization is required in this Contract.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for an Inpatient admission is the date of admission; except, as otherwise specified in Covered Services.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services – All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Creditable Coverage – Prior coverage you had from a group plan, Medicare, Medicaid, Indian Health Service, state risk pool, state children's health insurance program, public health plan, Peace Corps service, U.S. Government plans, foreign health plans or individual health plan. Prior coverage does not count as creditable if there was a break in coverage of 63 days or more prior to enrolling for coverage under this Plan.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- assistance with walking, bathing, or dressing;
- transfer or positioning in bed;
- normally self-administered medicine;
- meal preparation;
- feeding by utensil, tube, or gastrostomy;
- oral hygiene;
- ordinary skin and nail care;
- catheter care;
- suctioning;
- using the toilet;
- enemas; and
- preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible - The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

You may have a Deductible that applies to medical services and a separate Deductible that applies to Prescription Drugs. In this case, the Deductibles are separate and amounts applied to one will not apply

to the other. For example, amounts applied to the medical Deductible will not apply to the Prescription Drug Deductible. Other benefits that may include a separate Deductible are Dental and Vision Services (if applicable). You can refer to the Schedule of Cost Shares and Benefits for Deductible amounts, what services apply to the Deductible and if there are separate Deductibles.

Dependent - A person of the Subscriber's family who is eligible for coverage under the Contract as described in the **Eligibility and Enrollment** section.

Diagnostic Service - A test or procedure performed when you have specific symptoms to detect or to monitor your disease or condition. It must be ordered by a Provider. Covered Diagnostic Services are limited to those services specifically listed in the **Covered Services** section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date - The date when a Subscriber's coverage begins under this Contract. A Dependent's coverage also begins on the Subscriber's Effective Date, unless otherwise specified.

Eligible Person - A person who satisfies the Plan's eligibility requirements and is entitled to apply to be a Subscriber.

Emergency Medical Condition (Emergency) - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency Services (Emergency Care) - With respect to an Emergency Medical Condition:

1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

2) Within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment to stabilize the patient.

The term "stabilize" means, with respect to an Emergency Medical Condition:

To provide such medical treatment of the condition as many be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to delivery (including the placenta), if there is inadequate time to effect a safe transfer to another hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollment Date – The date coverage begins for a Member.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of Precertification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-expedited review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

Experimental/Investigative - A Drug, device or medical treatment or procedure that:

- has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law; or
- reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its standard means of treatment or diagnosis. Reliable evidence means only the published reports and articles and authoritative medical and scientific literature, written protocol or protocols by the treating facility or other facility studying substantially the same Drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facilities studying substantially the same Drug, device or medical treatment or procedure.

We may consult with professional peer review committees or other appropriate sources for recommendations.

External Grievance -- Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Contract.

Family Coverage - Coverage for the Subscriber and eligible Dependents.

Formulary – The term Formulary means a listing of Prescription Drugs that are determined by Anthem in its sole discretion to be designated as Covered drugs. The List of approved Prescription Drugs developed by Anthem in consultation with Physicians and Pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs, and may be different than the Formulary for other Anthem products. Generally, it includes select Generic Drugs with limited brand Prescription Drugs coverage. This list is subject to periodic review and modification by Anthem. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.anthem.com

Generic Drugs -- The term Generic Drugs means a Prescription Drug that the PBM has classified as Generic Drugs through use of an independent proprietary industry database. Generic Drugs have the same active ingredients, must meet the same FDA rules for safety, purity and potency, and must be given in the same form (tablet, capsule, cream) as the Brand Name Drug.

Grievance -- Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or medically necessary;
- a determination that a proposed service is experimental or investigational;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan.

Hospice Care -- A coordinated plan of home, Inpatient and Outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a

Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Identification Card/ID Card -- A card issued by the Plan that bears the Member's name, identifies the membership by number, and may contain information about your coverage. It is important to carry this card with you.

Inpatient -- A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. It does not mean a Member who is placed under observation for fewer than 24 hours.

Mail Service - Our Prescription management program which offers you a convenient means of obtaining Maintenance Medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maintenance Medications – A Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure if the Prescription Drug you are taking is a Maintenance Medication, please call Customer Service at the number on the back of your Identification Card or check Our website at www.anthem.com for more details.

Maximum Allowable Amount -- The maximum amount that We will pay for Covered Services you receive. For more information, see the "Claims Payment" section.

Medically Necessary or Medical Necessity –

Services rendered for the diagnosis or treatment of a condition that are generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice. The level and amount of services must not be greater than is necessary and appropriate according to said standards; for example, Inpatient services are not Medically Necessary if the services could have been appropriately provided as Outpatient services according to said standards. Services will not be considered Medically Necessary simply because they are rendered or prescribed by the Member's Physician or other Provider. We may consult with professional peer review committees or other appropriate sources for recommendations.

Medicare -- The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member -- A Subscriber or Dependent who has satisfied the eligibility conditions; applied for coverage; been approved by the Plan; and for whom Premium payment has been made. Members are sometimes called "you" and "your".

Mental Health and Substance Abuse - is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

Network Provider - A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administration functions to you for the network associated with this Contract.

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Facility – A Provider who has entered into a contractual agreement or is otherwise engaged by Us, or with another organization which has an agreement with Us, to provide Covered Services and certain administrative functions to you for the network associated with this Contract. A Hospital may be a Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

New FDA Approved Drug Product or Technology -- The first release of the Brand Name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- new formulations: a new dosage form or new formulation of an active ingredient already on the market;
- already marketed drug product but new manufacturer; a product that duplicates another firm's already marketed drug product (same active ingredient, formulation, or combination);
- already marketed drug product, but new use: a new use for a drug product already marketed by the same or a different firm; or
- newly introduced generic medication (generic medications contain the same active ingredient as their counterpart brand-named medications).

Non-Network Provider -- A Provider who has not entered into a contractual agreement with Us or is not otherwise engaged by Us for the network associated with this Contract. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Contract are also considered Non-Participating/Network Providers.

Non-Network Specialty Pharmacy - Any Pharmacy which has not entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Non-Network Transplant Facility -- Any Hospital which has not contracted with the transplant network engaged by Us to provide Covered Transplant Procedures. A Hospital may be a Non-Network Transplant Facility with respect to:

- Certain Covered Transplant Procedures; or
- All Covered Transplant Procedures.

Non-Participating Pharmacy - The term Non-Participating Pharmacy means a Pharmacy that does not have a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. In most instances, you will be responsible for a larger portion of your pharmaceutical bill when you go to a Non-Participating Pharmacy.

Out-of-Pocket Limit - A specified dollar amount of expense incurred for Covered Services in a calendar year as listed in the Schedule of Cost-Shares and Benefits. Such expense does not include charges in excess of the Maximum Allowed Amount or any non-Covered Services. Refer to the Schedule of Cost-Shares and Benefits for other services that may not be included in the Out-of-Pocket Limit. When the Out-of-Pocket Limit is reached, no additional Deductible or Coinsurance is required unless otherwise specified in this Contract.

Outpatient -- A Member who receives services or supplies while not an Inpatient.

Participating Pharmacy - The term Participating Pharmacy means a Pharmacy that has a Participating Pharmacy agreement in effect with or for the benefit of Anthem at the time services are rendered. Participating Pharmacies may be based on a restricted network, and may be different than the network of Participating Pharmacies for other Anthem products. To find a participating pharmacy near you, call customer service at 1-800-700-2533.

Pharmacy - The term Pharmacy means a place licensed by state law where you can get Prescription Drugs and other medicines from a licensed pharmacist when you have a prescription from your Doctor.

Pharmacy and Therapeutics (P&T) Committee -- a committee of physicians and pharmacists who review literature and studies which address the safety, efficacy, approved indications, adverse effects, contraindications, medical outcome, and pharmacoeconomics. The committee will develop, review

and/or approve guidelines related to how and when certain drugs and/or therapeutic categories will be approved for coverage.

Pharmacy and Therapeutics (P&T) Process - The term Pharmacy and Therapeutics means process to make clinically based recommendations that will help you access quality, low cost medicines within your Benefit Program. The process includes health care professionals such as nurses, pharmacists, and Doctors. The committees of the WellPoint National Pharmacy and Therapeutics Process meet regularly to talk about and find the clinical and financial value of medicines for our Members. This process first evaluates the clinical evidence of each product under review. The clinical review is then combined with an in-depth review of the market dynamics, Member impact and financial value to make choices for the Formulary. Our programs may include, but are not limited to, Drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, and Drug profiling initiatives.

Plan (We, Us, Our) –Anthem Insurance Companies, Inc. which provides or arranges for Members to receive the Covered Services which are described in this Contract.

Plan Year - The term Plan Year means a consecutive 12 month period during which a health plan provides coverage for the health benefits. A Plan Year may be a Calendar Year or otherwise.

Premium -- The periodic charges which the Subscriber must pay the Plan to maintain coverage.

Prescription Drug (Drug): The term Prescription Drug means a medicine that is made to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

1. Compounded (combination) medications, which contain at least one such medicinal substance, and is not essentially a copy of a commercially available drug product.
2. Insulin, diabetic supplies, and syringes.

Prescription Order -- A written request by a Provider, as permitted by law, for a drug or medication and each authorized refill for same.

Primary Care Physician ("PCP") – A Network provider who is a practitioner that specialized in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization --The process applied to certain services, supplies, treatment, and certain drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

Provider - A professional or Facility licensed by law that gives health care services within the scope of that license and is approved by Us. This includes any Provider that state law says We must cover when they give you services that state law says We must cover. Providers that deliver Covered Services are described throughout this Contract. If you have a question about a Provider not described in this Contract please call the number on the back of your Identification Card.

- **Alcoholism Treatment Facility –** A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.

- **Alternative Care Facility** – A non-hospital health care facility, or an attached facility designated as free standing by a Hospital, that the Plan approves, which provides Outpatient Services primarily for but not limited to:

    - Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI);
    - Surgery;
    - Therapy Services or rehabilitation.

- **Ambulatory Surgical Facility** - A facility Provider, with an organized staff of Physicians that:
    - Is licensed as such, where required;
    - Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
    - Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
    - Does not provide Inpatient accommodations; and
    - Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- **Birthing Center -** a Provider, other than a Hospital, where births take place following normal, uncomplicated pregnancies. Such centers must be:
    1. constituted, licensed, and operated as set forth in the laws that apply;
    2. equipped to provide low-risk maternity care;
    3. adequately staffed with qualified personnel who:
        a. provide care at childbirth;
        b. are practicing within the scope of their training and experience; and
        c. are licensed if required; and
    4. equipped and ready to initiate emergency procedures in life threatening events to mother and baby by personnel who are certified in Advanced Cardiac Life-Saving Skills.

- **Certified Advance Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Certified Nurse Midwife -** When services are supervised and billed for by an employer Physician.

- **Certified Registered Nurse Anesthetist** - Any individual licensed as a Registered Nurse by the state in which he or she practices, who holds a certificate of completion of a course in anesthesia approved by the American Association of Nurse Anesthetists or a course approved by that state's appropriate licensing board and who maintains certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists.

- **Certified Surgical Assistant -** A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

- **Chiropractor -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.

- **Day Hospital –** A facility that provides day rehabilitation services on an Outpatient basis.

- **Dialysis Facility -** A facility Provider which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Home Health Care Agency** - A public or private agency or organization licensed in the state in which it is located to provide Home Health Care Services, which:

  - Provides skilled nursing and other services on a visiting basis in the Member's home; and

  - Is responsible for supervising the delivery of such services under a plan prescribed
    and approved in writing by the attending Physician.

- **Home Infusion Facility –** A facility which provides a combination of:

  - Skilled nursing services

  - Prescription Drugs

  - Medical supplies and appliances

in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- **Hospital** -- A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. provides room and board and nursing care for its patients;

  2. has a staff with one or more Physicians available at all times;

  3. provides 24 hour nursing service;

  4. maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and

  5. is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

  The term Hospital does not include a Provider, or that part of a Provider, used mainly for:

  1. nursing care;

  2. rest care;

3. extended care;
4. convalescent care;
5. care of the aged;
6. Custodial Care;
7. educational care;
8. treatment of Mental Health Disorders;
9. treatment of alcohol or drug abuse.

- **Laboratory (Clinical) -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Licensed Practical Nurse –** When services are supervised and billed for by an employer Physician.
- **Occupational Therapist -** A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves.
- **Outpatient Psychiatric Facility –** A facility which mainly provides diagnostic and therapeutic services for the treatment of Mental Health Disorders on an Outpatient basis.
- **Pharmacy** -- An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.
- **Physician** --

1. a legally licensed doctor of medicine, doctor of osteopathy, or optometry; or
2. any other legally licensed practitioner of the healing arts rendering services which are:
    a. covered by the Plan;
    b. required by law to be covered when rendered by such practitioner; and
    c. within the scope of his or her license.

Physician does not include:

1. the Member; or
2. the Member's spouse, parent, child, sister, brother, or in-law.

- **Psychologist –** A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.

- **Registered Nurse -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse First Assistant -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Registered Nurse Practitioner -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Regulated Physician's Assistant –** When services are supervised and billed for by an employer Physician.

- **Rehabilitation Hospital –** A facility that is primarily engaged in providing rehabilitation services on an Inpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.

- **Respiratory Therapist (Certified) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Skilled Nursing Facility** -- A Provider constituted, licensed, and operated as set forth in applicable state law, which:

    1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;

    2. provides care supervised by a Physician;

    3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

    4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and

    5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker –** A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must e certified by the appropriate professional body.

- **Speech Therapist (Licensed) -** A duly licensed person that provides services within the scope of an applicable license and is a person that the Plan approves.

- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**

- **Urgent Care Center --** A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

Recovery – A Recovery is money you receive from another, their insurer or from any "Uninsured Motorist", "Underinsured Motorist", "Medical-Payments", "No-Fault", or "Personal Injury Protection" or other insurance coverage provision as a result of injury or illness caused by another. Regardless of how you or your representative or any agreements characterize the money you receive, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

Respite Care – Short-term, temporary care for people with disabilities, provided by persons trained in the behavioral management of persons with pervasive developmental disorders under the supervision of a professional licensed or certified to provide Mental Health Disorder services. The care must be provided at facilities that meet the state and/or local licensing certification requirements.

Self-Administered Injectable Drugs - The term Self-Administered Injectable Drugs means drugs that are injected which do not require a medical professional to administer.

Service Area -- The geographical area within which Our Covered Services are available as approved by state regulatory agencies.

Single Coverage -- Coverage for the Subscriber only.

Skilled Care -- Care which is Medically Necessary and must be performed or supervised by a skilled licensed professional in the observation and/or assessment of treatment of an illness or injury. It is ordered by a Physician and usually involves a treatment plan.

Specialty Care Physician (**SCP**) – A Network provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Specialty Drugs - The term Specialty Drugs means drugs that are high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient's drug therapy by a medical professional. These Drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies.

Small Employer – Any person, firm, corporation, limited liability company, partnership, or association actively engaged in business who, on a least fifty (50%) percent of the working days of the employer during the preceding year, employed at least two (2) but not more than fifty (50) Eligible Subscribers, the majority of whom work in Indiana. Companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one (1) employer.

Stabilize -- The provision of medical treatment to you in an emergency as may be necessary to assure, within reasonable medical probability that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you;
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor -- The Plan may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber – An Eligible Person in whose name this Contract has been issued, whose coverage is in effect and whose name appears on the Identification Card as Subscriber.

Therapy Services - Services and supplies used to promote recovery from an illness or injury. Covered Therapy Services are limited to those services specifically listed in the **Covered Services** section.

Tier One Drugs - This tier includes low cost and preferred Drugs that may be Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Two Drugs - This tier includes preferred Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Three Drugs - This tier includes Drugs considered Generic Drugs, single source Brand Name Drugs, or multi-source Brand Name Drugs.

Tier Four Drugs - This tier contains high cost Drugs. This includes Drugs considered Generic Drugs, single source Brand Name Drugs, and multi-source Brand Name Drugs. This tier also contains Specialty Drugs.