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State of Indiana - CDHP 2 - Combined

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1/1/2013

ANTHEA-CDHPII 2011

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1 Health Certificate **M-1**

Underwritten by Anthem Insurance Companies, Inc.

Anthem BlueCross BlueShield

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Your Health Certificate

Health Certificate of Coverage

(herein called the "Certificate")

Blue Access for Health Savings Accounts

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

ANTHEA-CDHPII 2011

1 INTRODUCTION

This Certificate is the legal document explaining your coverage. Please read this Certificate carefully, and refer to it whenever you require medical services.

The Certificate explains many of the rights and obligations between you and Us. It also describes how to get medical care, what health services are covered and not covered, and what portion of the health care costs you will be required to pay. Many of the provisions in this Certificate are interrelated; therefore, reading just one or two sections may not give you an accurate impression of your coverage. You are responsible for knowing the terms of this Certificate.

This Health Certificate overrides and replaces any Health Certificate previously issued to you. The coverage described in this Certificate is based upon the conditions of the Group Contract issued to your employer, and is based upon the benefit plan that your Group chose for you. The Group Contract, this Certificate and any endorsements, amendments or riders attached, form the Group Contract under which Covered Services are available under your health care benefits.

Many words used in the Certificate have special meanings. These words are capitalized. If the word or phrase was not explained in the text where it appears, it may be defined in the "Definitions" section. Refer to these definitions for the best understanding of what is being stated.

If you have any questions about this Certificate, please call the member service number located on the back of your Identification (ID) Card or visit www.anthem.com.

How to Obtain Language Assistance

We are committed to communicating with Our Members about their health plan, regardless of their language. We employ a language line interpretation service for use by all of Our Customer Service call centers. Simply call the Customer Service phone number on the back of your ID card and a representative will be able to assist you. Translation of written materials about your benefits can also be requested by contacting Customer Service.

President

2 FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES

Choice of Primary Care Physician

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

Access to Obstetrical and Gynecological (ObGyn) Care

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

3 YOUR RIGHTS AND RESPONSIBILITIES AS AN ANTHEM BLUE CROSS BLUE SHIELD MEMBER

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

You have the right to:

- Speak freely and privately with your doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it's covered under your plan.
- Work with your doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and federal laws, and Our privacy rules.
- Get information about Our company and services, and Our network of doctors and other health care Providers.
- Get more information about your rights and responsibilities and give Us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
    - Your health care plan
    - Any care you get
    - Any Covered Service or benefit ruling that your health care plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your doctor tell you how that may affect your health now and in the future.
- Participate in matters that deal with Our policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a doctor or other health care professional. When it seems that you will not be able to understand certain information that information will be given to someone else that you choose.
- Get help at any time, by contacting your local insurance department.

You have the responsibility to:

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

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

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

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4 SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Certificate for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate including any endorsements, amendments, or riders.

This Schedule of Benefits lists the Member's responsibility for Covered Services.

To receive maximum benefits at the lowest Out-Of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use a Non-Network Provider you are responsible for any balance due between the Non-Network Provider's charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges.

Copayments/Coinsurance/Maximums are calculated based upon the Maximum Allowable Amount, not the Provider's charge.

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

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

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

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

BENEFIT PERIOD	Calendar Year
DEPENDENT AGE LIMIT	To the dependent's 26th birthday. For additional Dependent Information such as Disabled Dependent eligibility, see the Eligibility and Enrollment section of this Certificate.

DEDUCTIBLE

	Network	Non-Network
Single	$1,500 Network and Non-Network combined	
Per Family	$3,000 Network and Non-Network combined	

Note: All medical and Prescription Drug Copayments/Coinsurance are subject to the Deductible and apply to the Out-of-Pocket Limit except for Non-Network Human Organ and Tissue Transplant Copayments/Coinsurance. The Deductible must be satisfied before any Covered Services are paid by the Plan except for services with no Copayment/Coinsurance.

OUT-OF-POCKET LIMIT

	Network	Non-Network
Single	$3,000 Network and Non-Network combined	
Per Family	$6,000 Network and Non-Network combined	

Note: **The Out-of-Pocket Limit includes all Deductibles and/or Copayments/Coinsurance you incur in a Benefit Period except for Non-Network Human Organ and Tissue Transplant Copayments/Coinsurance.** Once the Member and/or Family Out-of-Pocket Limit is satisfied, no additional Copayments/Coinsurance will be required for the Member and/or Family for the remainder of the Benefit Period except for Non-Network Human Organ and Tissue Transplant services.

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

COVERED SERVICES	COPAYMENTS/COINSURANCE/MAXIMUMS	
	Network	**Non-Network**
Ambulance Services	20% Coinsurance	20% Coinsurance
Behavioral Health Services	20% Coinsurance	40% Coinsurance
Note: Coverage for the treatment of Behavioral Health and Substance Abuse conditions is provided in compliance with state and federal law.		
Dental Services (only when related to accidental injury or for certain members requiring general anesthesia)	20% Coinsurance	40% Coinsurance

Diagnostic Services	When rendered as Physician Home Visits and Office Services or Outpatient Services the Co-payment/Coinsurance is based on the setting where Covered Services are received except as listed below. Other Diagnostic Services and or tests, including services received at an independent Network lab, may not require a Co-payment/Coinsurance. Laboratory services provided by a facility participating in Our Laboratory Network (as shown in the provider directory) may not require a Coinsurance/Copayment. If laboratory services are provided by an Outpatient Hospital laboratory which is not part of Our Laboratory Network, even if it is a Network Provider for other services, they will be covered as an Outpatient Services benefit.	

Note: MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services are subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Emergency Room Services	20% Coinsurance	Covered Services are always paid at the Network level. However, Non-Network Providers may also bill you for any charges that exceed the Maximum Allowable Amount.
Home Care Services	20% Coinsurance	40% Coinsurance
Maximum Visits per Benefit Period	Unlimited, combined Network and Non-Network	

NOTE: Maximum does not include Home Infusion Therapy or Private Duty Nursing rendered in the home.

Private Duty Nursing Lifetime Maximum	$5,000 per Member	
Hospice Services	20% Coinsurance	20% Coinsurance
Inpatient and Outpatient Professional Services	20% Coinsurance	40% Coinsurance
Inpatient Facility Services	20% Coinsurance	40% Coinsurance

Maximum days per Benefit Period for Physical Medicine and Rehabilitation (includes Day Rehabilitation Therapy services on an Outpatient basis)	Unlimited, combined Network and Non-Network	
Mammograms (Outpatient - diagnostic & routine)	Please see the "Preventive Care Services" provision in this Schedule.	
Maternity Services	20% Coinsurance	40% Coinsurance
Medical Supplies, Durable Medical Equipment and Appliances (Includes certain diabetic and asthmatic supplies when obtained from a Non-Network Pharmacy.)	20% Coinsurance	40% Coinsurance

NOTE: Prosthetic limbs (artificial leg or arm) or an Orthotic custom fabricated brace or support designed as a component for a Prosthetic limb are covered the same as any other Medically Necessary items and services and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

NOTE: If durable medical equipment or appliances are obtained through your Primary Care Physician or another Network Physician's office, Urgent Care Center Services, Outpatient Services, Home Health Care Services the Copayment/Coinsurance listed above will apply in addition to the Copayment/Coinsurance in the setting where Covered Services are received.

Outpatient Services		
Other Outpatient Services	20% Coinsurance	40% Coinsurance

Note: Physical Medicine Therapy through Day Rehabilitation Programs is subject to the Other Outpatient Services Copayment/Coinsurance regardless of setting where Covered Services are received.

Outpatient Surgery Hospital/Alternative Care Facility	20% Coinsurance	40% Coinsurance
Physician Home Visits and Office Services		
Primary Care Physician (PCP)	20% Coinsurance	40% Coinsurance
Specialty Care Physician (SCP)	20% Coinsurance	40% Coinsurance
Allergy Injections	20% Coinsurance	40% Coinsurance

NOTES: Allergy testing, MRA, MRI, PET scan, CAT scan, nuclear cardiology imaging studies, and non-maternity related ultrasound services received in a Physician's office are subject to the Other Outpatient Services Copayment/Coinsurance.
The allergy injection Copayment/Coinsurance will be applied when the injection(s) is billed by itself. The office visit Copayment/Coinsurance will apply if an office visit is billed with an allergy injection.

Preventive Care Services	No Copayment / Coinsurance up to the Maximum Allowable Amount	40% Coinsurance (not subject to Deductible)
Surgical Services	20% Coinsurance	40% Coinsurance
Temporomandibular Joint (TMJ) Services (surgical and non-surgical)	20% Coinsurance	40% Coinsurance
Therapy Services	20% Coinsurance	40% Coinsurance

NOTE: If different types of Therapy Services are performed during one Physician Home Visit, Office Service, or Outpatient Service, then each different type of Therapy Service performed will be considered a separate Therapy Visit. Each Therapy Visit will count against the applicable Maximum Visits listed below. For example, if both a Physical Therapy Service and a Manipulation Therapy Service are performed during one Physician Home Visit, Office Service, or Outpatient Service, they will count as both one Physical Therapy Visit and one Manipulation Therapy Visit.

Maximum Visits per Benefit Period for:	
Physical Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Occupational Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Speech Therapy	25 visits when rendered as Physician Home Visits and Office Services or Outpatient Services, combined Network and Non-Network. When rendered in the home, Home Care Services limits apply.
Manipulation Therapy	12 visits combined Network & Non-Network

Urgent Care Center Services	20% Coinsurance	20% Coinsurance. You are responsible for any amounts charged that exceed Our Maximum Allowable Amount.

Human Organ and Tissue Transplant Services

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

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

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to applicable Member cost shares.

Transplant Benefit Period	**Network Transplant Provider** Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 - 50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility.	**Non-Network Transplant Provider** The later of 30 days or date of discharge following a Covered Transplant Procedure at a Non Network Transplant Provider Facility.
Deductible	**Network Transplant Provider** Applicable	**Non-Network Transplant Provider** Applicable During the Transplant Benefit Period, Covered Transplant Procedure charges that count toward the Deductible will NOT apply to your Out-of-Pocket Limit.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider** 20% Coinsurance Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.	**Non-Network Transplant Provider** During the Transplant Benefit Period, You will pay 40% of the Maximum Allowable Amount. During the Transplant Benefit Period, Covered Transplant Procedure charges at a Non-Network Transplant Provider Facility will NOT apply to your Out-of-Pocket Limit.

		If the Provider is also a Network Provider for this Certificate (for services other than Transplant Services and Procedures), then you will **not** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. If the Provider is a Non-Network Provider for this Certificate, you **will** be responsible for Covered Services which exceed the Plan's Maximum Allowable Amount. Prior to and after the Transplant Benefit Period, Covered Services will be paid as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed.
Covered Transplant Procedure during the Transplant Benefit Period	**Network Transplant Provider Professional and Ancillary (non-Hospital) Providers** 20% Coinsurance	**Non-Network Transplant Provider Professional and Ancillary (non-Hospital) Providers** You are responsible for 40% of Maximum Allowable Amount. These charges will NOT apply to your Out-of-Pocket Limit.
Transportation and Lodging	Covered, as approved through the plan's prior approval and precertification process, up to a $10,000 benefit limit	For Transplants received at a Non-Network Transplant Provider Facility, covered as approved through the plan's prior approval and precertification process, up to a maximum of $10,000 in charges. You will pay 40% of the approved amount. These charges will NOT apply to your Out-of-Pocket Limit.
Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure	Covered, as approved through the plan's prior approval and precertification process, up to a $30,000 benefit limit	Covered, as approved through the plan's prior approval and precertification process, up to a $30,000 benefit limit. You will be responsible for 40% of search charges. These charges will NOT apply to your Out-of-Pocket Limit.

Live Donor Health Services	Covered as approved through the plan's prior approval and precertification process	You will pay 40% of the Plan's Maximum Allowable Amount for Medically Necessary live organ donor expenses. Covered expenses include complications from the donor procedure for up to six weeks from the date of procurement.

Prescription Drugs

Days Supply: Days Supply may be less than the amount shown due to Prior Authorization, Quantity Limits, and/or age limits and Utilization Guidelines.

Retail Pharmacy (Network and Non-Network)	30 days
Mail Service	90 days
Retail Specialty Pharmacy (Network & Non-Network) and Specialty Mail Service	30 days

Please note that the Copayments/Coinsurance below will not apply until after the Deductible is met.

Network Retail Pharmacy Prescription Drug Copayment/Coinsurance

Tier 1 Prescription Drugs	$10 Copayment per Prescription Order
Tier 2 Prescription Drugs	20% Coinsurance (minimum $30; maximum $50) per Prescription Order
Tier 3 Prescription Drugs	40% Coinsurance (minimum $50; maximum $70) per Prescription Order

The PBM's Network Mail Service Program Prescription Drug Copayment/Coinsurance:

Tier 1 Prescription Drugs	$20 Copayment per Prescription Order
Tier 2 Prescription Drugs	20% Coinsurance (minimum $60; maximum $100) per Prescription Order
Tier 3 Prescription Drugs	40% Coinsurance (minimum $100; maximum $140) per Prescription Order

Specialty Network Retail Including Specialty Mail Service Program Prescription Drug Copayment/Coinsurance:	40% Coinsurance (minimum $75; maximum $150) per Prescription Order
Non-Network Retail Pharmacy Prescription Drug Copayment / Coinsurance:	40% Coinsurance per Prescription Order

Orally Administered Cancer Chemotherapy	After Deductible has been satisfied, no Copayment /Coinsurance will apply to orally administered cancer chemotherapy when obtained from a Network Pharmacy, Mail Service Program, or Specialty Pharmacy Network. After Deductible has been satisfied, no Copayment /Coinsurance will apply to orally administered cancer chemotherapy obtained from a Non-Network Pharmacy up to the Maximum Allowable Amount; you will be responsible for the amount that exceeds the Maximum Allowable Amount, up to billed charges. As required by Indiana law, benefits for orally administered cancer chemotherapy will not be less favorable than the benefits that apply to coverage for cancer chemotherapy that is administered intravenously or by injection.

Note: Certain Diabetic and asthmatic supplies are covered subject to applicable Prescription Drug Copayments/Coinsurance when obtained from a Network Pharmacy. These supplies are covered as Medical Supplies, Durable Medical Equipment, and Appliances if obtained from a Non-Network Pharmacy. Diabetic test strips are covered subject to applicable Prescription Drug Copayment/Coinsurance.

5 COVERED SERVICES

This section describes the Covered Services available under your health care benefits when provided and billed by Providers. **For most services, care must be received from a Primary Care Physician (PCP), Specialty Care Physician (SCP) or another Network Provider to be a Covered Service, except for Emergency Care and Urgent Care. Services which are not received from a PCP, SCP or another Network Provider or approved as an Authorized Service will be considered a Non-Network service, except as specified above.** The amount payable for Covered Services varies depending on whether you receive your care from a PCP, SCP or another Network Provider or a Non-Network Provider, except for Emergency Care and Urgent Care.

If you use a Non-Network Provider, you are responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible. We cannot prohibit Non-Network Providers from billing you for the difference in the Non-Network Provider's charge and the Maximum Allowable Amount.

All Covered Services and benefits are subject to the conditions, Exclusions, limitations, terms and provisions of this Certificate, including any attachments, riders and endorsements. Covered Services must be Medically Necessary and not Experimental/Investigative. The fact that a Provider may prescribe, order, recommend or approve a service, treatment or supply does not make it Medically Necessary or a Covered Service and **does not** guarantee payment. To receive maximum benefits for Covered Services, you must follow the terms of the Certificate, including receipt of care from a PCP, SCP or another Network Provider, and obtain any required Prior Authorization or Precertification. Contact your Network Provider to be sure that Prior

Authorization/Precertification has been obtained. We base Our decisions about Prior Authorization, Precertification, Medical Necessity, Experimental/Investigative services and new technology on Our clinical coverage guidelines and medical policy. We may also consider published peer-review medical literature, opinions of experts and the recommendations of nationally recognized public and private organizations which review the medical effectiveness of health care services and technology.

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

Ambulance Services

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

Ambulance Services are transportation by a vehicle (including ground, water, fixed wing and rotary wing air transportation) designed, equipped and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals:

- From your home, scene of accident or medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and Skilled Nursing Facility; or
- From a Hospital or Skilled Nursing Facility to your home.

Treatment of a sickness or injury by medical professionals from an Ambulance Service when you are not transported will be covered if Medically Necessary.

Other vehicles which do not meet this definition, including but not limited to ambulettes, are not Covered Services.

Ambulance services are a Covered Service only when Medically Necessary, except:

- When ordered by an employer, school, fire or public safety official and the Member is not in a position to refuse; or
- When a Member is required by Us to move from a Non-Network Provider to a Network Provider.

Ambulance trips must be made to the closest local facility that can give Covered Services appropriate for your condition. If none of these facilities are in your local area, you are covered for trips to the closest facility outside your local area. Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service.

Non Covered Services for Ambulance include but are not limited to, trips to:

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

Behavioral Health Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for Inpatient Services, Outpatient Services, and Physician Home Visits & Office Services for the treatment of Behavioral Health conditions is provided in compliance with state and federal law.

Cancer Clinical Trials

Benefits are available for services for routine patient care rendered as part of a cancer clinical trial if the services are otherwise Covered Services under this Certificate and the clinical trial is performed:

- using a particular care method to prevent, diagnose, or treat a cancer for which:
  1. there is no clearly superior, non-investigational alternative care method; and
  2. available clinical or preclinical data provides a reasonable basis from which to believe that the care method used in the research study is at least as effective as any non-investigational alternative care method; and
- in a facility where personnel providing the care method to be followed in the research study have:
  1. received training in providing the care method;
  2. expertise in providing the type of care required for the research study; and
  3. experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and
- to scientifically determine the best care method to prevent, diagnose, or treat the cancer; and
- the trial is approved or funded by one of the following:
  1. The National Institute of Health, or one of its cooperative groups or centers under the United States Department of Health and Human Services;
  2. The United States Food and Drug Administration;
  3. The United States Department of Defense;
  4. The United States Department of Veteran's Affairs;
  5. The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks; or
  6. A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

Benefits do not, however, include the following:

- A health care service, item, or drug that is the subject of the cancer clinical trial or is provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;

- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the health care service, item, or investigational drug that is the subject of the clinical trial;
- An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- Transportation, lodging, food, or other expenses for the patient, or a family member or companion of the patient, that are associated with the travel to or from a facility providing the cancer clinical trial;
- An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsor of the cancer clinical trial.

Dental Services

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

Related to Accidental Injury

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

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

- oral examinations.
- x-rays.
- tests and laboratory examinations.
- restorations.
- prosthetic services.
- oral surgery.
- mandibular/maxillary reconstruction.
- anesthesia.

Other Dental Services

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

Diabetic Equipment, Education and Supplies

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

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

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

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

Covered Services also include all Physician prescribed Medically Necessary equipment and supplies used for the management and treatment of diabetes. See "Medical Supplies, Durable Medical Equipment and Appliances", "Preventive Care Services", and "Physician Home Visits and Office Services". Screenings for gestational diabetes are covered under "Preventive Care."

Diagnostic Services

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

Diagnostic services are tests or procedures performed when you have specific symptoms, to detect or monitor your condition. Coverage for Diagnostic Services, including when provided as part of Physician Home Visits and Office Services, Inpatient Services, Outpatient Services, Home Care Services, and Hospice Services includes but is not limited to:

- X-ray and other radiology services, including mammograms for any person diagnosed with breast disease.
- Magnetic Resonance Angiography (MRA).
- Magnetic Resonance Imaging (MRI).
- CAT scans.

- Laboratory and pathology services.
- Cardiographic, encephalographic, and radioisotope tests.
- Nuclear cardiology imaging studies.
- Ultrasound services.
- Allergy tests.
- Electrocardiograms (EKG).
- Electromyograms (EMG) except that surface EMG's are not Covered Services.
- Echocardiograms.
- Bone density studies.
- Positron emission tomography (PET scanning).
- Diagnostic Tests as an evaluation to determine the need for a Covered Transplant Procedure.
- Echographies.
- Doppler studies.
- Brainstem evoked potentials (BAER).
- Somatosensory evoked potentials (SSEP)
- Visual evoked potentials (VEP)
- Nerve conduction studies.
- Muscle testing.
- Electrocorticograms.

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

For Diagnostic services other than those approved to be received in a Physician's office, you may be required to use Our independent laboratory Network Provider called the Reference Laboratory Network (RLN).

Emergency Care and Urgent Care Services

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

Emergency Care (including Emergency Room Services)

If you are experiencing an Emergency, call 9-1-1 or go to the nearest Hospital. Services which We determine to meet the definition of Emergency Care will be covered, whether the care is rendered by a Network Provider or Non-Network Provider. Emergency Care rendered by a Non-Network Provider will be covered as a Network service, however the Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Coinsurance, Copayment or Deductible.

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

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

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

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

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

Care and treatment provided once you are Stabilized is no longer considered Emergency Care. Continuation of care from a Non-Network Provider beyond that needed to evaluate or Stabilize your condition in an Emergency will be covered as a Non-Network service unless We authorize the continuation of care and it is Medically Necessary.

Urgent Care Center Services

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

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

See your Schedule of Benefits for benefit limitations.

Home Care Services

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

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

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

Non Covered Services include but are not limited to:

- Food, housing, homemaker services and home delivered meals.
- Home or Outpatient hemodialysis services (these are covered under Therapy Services).
- Physician charges.
- Helpful environmental materials (hand rails, ramps, telephones, air conditioners, and similar services, appliances and devices.)

- Services provided by registered nurses and other health workers who are not acting as employees or under approved arrangements with a contracting Home Health Care Provider.
- Services provided by a member of the patient's immediate family.
- Services provided by volunteer ambulance associations for which patient is not obligated to pay, visiting teachers, vocational guidance and other counselors, and services related to outside, occupational and social activities.

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

Hospice Services

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

Hospice care may be provided in the home or at a Hospice facility where medical, social and psychological services are given to help treat patients with a terminal illness. Hospice Services include routine home care, continuous home care, Inpatient Hospice and Inpatient respite. To be eligible for Hospice benefits, the patient must have a life expectancy of six months or less, as confirmed by the attending Physician. Covered Services will continue if the Member lives longer than six months.

When approved by your Physician, Covered Services include the following:

- Skilled Nursing Services (by an R.N. or L.P.N.).
- Diagnostic Services.
- Physical, speech and inhalation therapies if part of a treatment plan.
- Medical supplies, equipment and appliances (benefits will not be covered for equipment when the Member is in a Facility that should provide such equipment).
- Counseling services.
- Inpatient confinement at a Hospice.
- Prescription Drugs given by the Hospice.
- Home health aide.

Non Covered Services include but are not limited to:

- Services provided by volunteers.
- Housekeeping services.

Inpatient Services

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

Inpatient Services include:

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

Room, Board, and General Nursing Services

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

Ancillary (Related) Services

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

Professional Services

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

- **Surgery and the administration of general anesthesia.**
- **Newborn exam.** A Physician other than the Physician who performed the obstetrical delivery must do the examination.

Maternity Services

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

Maternity services include Inpatient Services, Outpatient Services and Physician Home Visits and Office Services. These services are used for normal or complicated pregnancy, miscarriage, therapeutic abortion (abortion recommended by a Provider), and ordinary routine nursery care for a healthy newborn. Abortion means the ending of a pregnancy before the birth of the infant. Miscarriage is a spontaneous abortion (occurs naturally and suddenly). A therapeutic abortion is one performed to save the life or health of the mother, or as a result of incest or rape.

If the Member is pregnant on her Effective Date and is in the first trimester of the pregnancy, she must change to a Network Provider to have Covered Services paid at the Network level. If the Member is pregnant on her Effective Date, benefits for obstetrical care will be paid at the Network level if the Member is in her second or third trimester of pregnancy (13 weeks or later) as of the Effective Date. Covered Services will include the obstetrical care provided by that Provider through the end of the pregnancy and the immediate post-partum period. The Member must complete a Continuation of Care Request Form and submit to Us.

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

If Maternity Services are not covered for any reason, Hospital charges for ordinary routine nursery care for a well newborn are also not covered.

Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if your attending Physician determines further Inpatient postpartum care is not necessary for you or your newborn child, provided the following are met and the mother concurs:

- In the opinion of your attending Physician, the newborn child meets the criteria for medical stability in the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon evaluation of:
    1. the antepartum, intrapartum, and postpartum course of the mother and infant;
    2. the gestational stage, birth weight, and clinical condition of the infant;
    3. the demonstrated ability of the mother to care for the infant after discharge; and
    4. the availability of post-discharge follow-up to verify the condition of the infant after discharge.
- Covered Services include at-home post delivery care visits at your residence by a Physician or Nurse performed no later than 48 hours following you and your newborn child's discharge from the Hospital. Coverage for this visit includes, but is not limited to:

1. parent education;
2. assistance and training in breast or bottle feeding; and
3. performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for you or your newborn child, including the collection of an adequate sample for the hereditary and metabolic newborn screening.

At your discretion, this visit may occur at the Physician's office.

In addition, coverage is provided for an examination given at the earliest feasible time to your newborn child for the detection of the following disorders:

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

Medical Supplies, Durable Medical Equipment, and Appliances

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

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

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

- The equipment, supply or appliance is a Covered Service;

- The continued use of the item is Medically Necessary;
- There is reasonable justification for the repair, adjustment, or replacement (warranty expiration is not reasonable justification).
- In addition, replacement of purchased equipment, supplies or appliance may be covered if:
  1. The equipment, supply or appliance is worn out or no longer functions.
  2. Repair is not possible or would equal or exceed the cost of replacement. An assessment by a rehabilitation equipment specialist or vendor should be done to estimate the cost of repair.
  3. Individual's needs have changed and the current equipment is no longer usable due to weight gain, rapid growth, or deterioration of function, etc.
  4. The equipment, supply or appliance is damaged and cannot be repaired.

We may establish reasonable quantity limits for certain supplies, equipment or appliance described below.

Covered Services may include, but are not limited to:

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

  Covered Services may include, but are not limited to:

  1. Allergy serum extracts
  2. Chem strips, Glucometer, Lancets
  3. Clinitest
  4. Elastic stockings or supports. These items must be purchased by prescription or through a Hospital. They must be Medically Necessary for the treatment of an injury or condition requiring stockings. We may establish reasonable limits on the number of pairs allowed per Member per Benefit Period.
  5. Needles/syringes
  6. Ostomy bags and supplies except charges such as those made by a Pharmacy for purposes of a fitting are not Covered Services.

  Non Covered Services include:

  1. Adhesive tape, band aids, cotton tipped applicators
  2. Arch supports
  3. Doughnut cushions
  4. Hot packs, ice bags
  5. vitamins

6. medi-jectors

If you have any questions regarding whether a specific medical or surgical supply is covered call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

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

  Covered Services may include, but are not limited to:

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

  Non-covered items include:

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

If you have any questions regarding whether a specific durable medical equipment is covered call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

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

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

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

Covered Services may include, but are not limited to:

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

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

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

If you have any questions regarding whether a specific prosthetic is covered call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

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

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

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

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

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

  Non-Covered Services include but are not limited to:

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

  If you have any questions regarding whether a specific orthotic is covered call the customer service number on the back of your Identification Card or visit Our website at www.anthem.com.

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

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

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

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

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

Outpatient Services

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

Outpatient Services include both facility, ancillary, facility use, and professional charges when given as an Outpatient at a Hospital, Alternative Care Facility, Retail Health Clinic, or other Provider as determined by the Plan. These facilities may include a non-Hospital site providing Diagnostic and therapy services, surgery, or rehabilitation, or other Provider facility as determined by Us. Professional charges only include services billed by a Physician or other professional.

When Diagnostic Services or Other Therapy Services (chemotherapy, radiation, dialysis, inhalation, or cardiac rehabilitation) is the only Outpatient Services charge, no Copayment is required if received as part of an Outpatient surgery. Any Coinsurance will still apply to these services.

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

Pervasive Developmental Disorder Services

Coverage is provided for the treatment of pervasive developmental disorders. Treatment is limited to services prescribed by your Physician in accordance with a treatment plan. Pervasive developmental disorder means a neurological condition, including Asperger's syndrome and autism, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. Any exclusion or limitation in this Certificate in conflict with the coverage described in this provision will not apply. Coverage for the treatment of pervasive developmental disorders will not be subject to dollar limits, Deductibles, Copayments or Coinsurance provisions that are less favorable than the dollar limits, Deductibles, Copayments or Coinsurance provisions that apply to a physical illness as covered under this Certificate.

Physician Home Visits and Office Services

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

Covered Services include care provided by a Physician in their office or your home. Refer to the sections titled "Preventive Care", "Maternity Care" and "Home Care Services" for services covered by the Plan. For Emergency Care refer to the "Emergency Care and Urgent Care" section.

Office visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in the Physician's office. Office visits also include allergy testing, injections and serum. When allergy serum is the only charge from a Physician's office, no Copayment is required. Coinsurance is not waived.

Home Visits for medical care and consultations to examine, diagnose, and treat an illness or injury performed in your home.

Diagnostic Services when required to diagnose or monitor a symptom, disease or condition.

Surgery and Surgical Services (including anesthesia and supplies). The surgical fee includes normal post-operative care.

Therapy Services for physical medicine therapies and other Therapy Services when given in the office of a Physician or other professional Provider.

Preventive Care Services

See the Schedule of Benefits for any applicable Deductible, Coinsurance, or Copayments.

Preventive Care services include, Outpatient services and Office Services. Screenings and other services are covered as Preventive Care for adults and children with no current symptoms or prior history of a medical condition associated with that screening or service.

Members who have current symptoms or have been diagnosed with a medical condition are not considered to require Preventive Care for that condition but instead benefits will be considered under the Diagnostic Services benefit.

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

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force.

   Examples of these services are screenings for:

   a. Breast cancer;
   b. Cervical cancer;
   c. Colorectal cancer;
   d. High Blood Pressure;
   e. Type 2 Diabetes Mellitus;
   f. Cholesterol;
   g. Child and Adult Obesity.

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

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, including the following:

   a. Women’s contraceptives, sterilization procedures, and counseling. This includes Generic as well as injectable contraceptives and patches. Contraceptive devices such as diaphragms, intra uterine devices (IUDs), and implants are also covered. Multi-source Brand Drugs will be covered under the Prescription Drug benefit.

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

c. Gestational diabetes screening.

You may call Customer Service using the number on your ID card for additional information about these services. (or view the federal government's web sites, http://www.healthcare.gov/center/regulations/prevention.html; or http://www.ahrq.gov/clinic/uspstfix.htm; http://www.cdc.gov/vaccines/recs/acip/.)

Covered Services also include the following services required by state and federal law:

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

Other Covered Services are:

- Routine hearing screenings
- Routine vision screenings

Surgical Services

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

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

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

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

Covered Surgical Services include, but are not limited to:

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

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

Surgical Services for Morbid Obesity, described in more detail below, shall be covered the same as any other Medically Necessary Surgical Service subject to any maximums in the Schedule of Benefits.

Reconstructive Services

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

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

Mastectomy Notice

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

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

This coverage will be provided in consultation with the patient and the patient's attending Physician and will be subject to the same annual Deductible, Coinsurance, Copayment provisions otherwise applicable under the Plan.

Morbid Obesity Treatment Services

Covered Services include surgical treatment of morbid obesity:

- that has persisted for at least five (5) years; and
- for which nonsurgical treatment supervised by a Physician has been unsuccessful for at least six (6) consecutive months.

Under state law, We cannot cover services for the surgical treatment of morbid obesity for a Member younger than 21 years of age unless two (2) Physicians licensed under Indiana Code 25-22.5 (one who holds the degree of doctor of medicine or doctor of osteopathy or its equivalent and who holds a valid unlimited license to practice medicine or osteopathic medicine in Indiana) determine that the surgery is necessary to:

- save the life of the Member; or
- restore the Member's ability to maintain a major life activity (self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency);

and each Physician documents in the Member's medical record the reason for the Physician's determination.

"Morbid obesity" means:

- a body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; or
- a body mass index of at least forty (40) kilograms per meter squared without comorbidity.

For purposes of this subsection, body mass index equals weight in kilograms divided by height in meters squared.

Surgical Treatment for Morbid Obesity may be limited. See the Schedule of Benefits.

Sterilization

Sterilization is a Covered Service. Sterilizations for women will be covered under the "Preventive Care" benefit. Please see that section for further details

Temporomandibular or Craniomandibular Joint Disorder and Craniomandibular Jaw Disorder

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

Benefits are provided for temporomandibular (joint connecting the lower jaw to the temporal bone at the side of the head) and craniomandibular (head and neck muscle) disorders.

Therapy Services

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

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

Physical Medicine Therapy Services

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

- **Physical therapy** including treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. Non Covered Services include but are not limited to: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

- **Speech therapy** for the correction of a speech impairment.

- **Occupational therapy** for the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational therapy does not include diversional, recreational, or vocational therapies (e.g. hobbies, arts and crafts). Non Covered Services include but are not limited to: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

- **Manipulation Therapy** includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments. Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

Other Therapy Services

- **Cardiac rehabilitation** to restore an individual's functional status after a cardiac event. It is a program of medical evaluation, education, supervised exercise training, and psychosocial support. Home programs, on-going conditioning and maintenance are not covered.
- **Chemotherapy** for the treatment of a disease by chemical or biological antineoplastic agents, including the cost of such agents.
- **Dialysis treatments** of an acute or chronic kidney ailment which may include the supportive use of an artificial kidney machine. As a condition of coverage the Plan will not require you to receive dialysis treatment at a Network Dialysis Facility if that facility is further than 30 miles from your home. If you require dialysis treatment and the nearest Network Dialysis Facility is more than 30 miles from your home, the Plan will allow you to receive treatment at a Non-Network Dialysis Facility nearest to your home as an Authorized Service.
- **Radiation therapy** for the treatment of disease by X-ray, radium, or radioactive isotopes. Includes treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources); materials and supplies used in therapy; treatment planning.
- **Inhalation therapy** for the treatment of a condition by the administration of medicines, water vapors, gases, or anesthetics by inhalation. Covered Services include but are not limited to, introduction of dry or moist gases into the lungs; nonpressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with our without nebulized medication; continuous positive airway pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.
- **Pulmonary rehabilitation** to restore an individual's functional status after an illness or injury. Covered Services include but are not limited to Outpatient short-term respiratory services for conditions which are expected to show significant improvement through short-term therapy. Also covered is inhalation therapy administered in Physician's office including but are not limited to breathing exercise, exercise not elsewhere classified, and other counseling. Pulmonary rehabilitation in the acute Inpatient rehabilitation setting is not a Covered Service.

Physical Medicine and Rehabilitation Services

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

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

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

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

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

Human Organ and Tissue Transplant Services

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

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

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

The above services are covered as Inpatient Services, Outpatient Services or Physician Home Visits and Office Services depending where the service is performed subject to Member cost shares.

Covered Transplant Procedure

Any Medically Necessary human organ and tissue transplants and transfusions as determined by Us including necessary acquisition procedures, harvest and storage, and including Medically Necessary preparatory myeloablative therapy.

Transplant Benefit Period

Starts one day prior to a Covered Transplant Procedure and continues for the applicable global time period (normally 34 - 50 days depending on the type of transplant received) for services received at a Network Transplant Provider Facility or the later of 30 days or date of discharge following a Covered Transplant Procedure at a Non-Network Transplant Provider Facility.

Prior Approval and Precertification

In order to maximize your benefits, We strongly encourage you to call Our transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before you have an evaluation and/or work-up for a transplant. We will assist you in maximizing your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are

applicable. Contact the Customer Service telephone number on the back of your Identification Card **and ask for the transplant coordinator**. Even if We issue a prior approval for the Covered Transplant Procedure, you or your Provider must call Our Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or Outpatient setting.

Please note that there are instances where your Provider requests approval for HLA testing, donor searches and/or a harvest and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The harvest and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a harvest and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

Transportation and Lodging

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

Certain Human Organ and Tissue Transplant Services may be limited. See the Schedule of Benefits.

Prescription Drug Benefits

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

Pharmacy Benefits Manager

The pharmacy benefits available to you under this Certificate are managed by Our Pharmacy Benefits Manager (PBM). The PBM is a pharmacy benefits management company with which We contract to manage your pharmacy benefits. The PBM has a nationwide network of retail pharmacies, a Mail Service pharmacy, a Specialty pharmacy, and provides clinical management services.

The management and other services the PBM provides include, among others, making recommendations to, and updating, the covered Prescription Drug list (also known as a Formulary) and managing a network of retail pharmacies, operating a Mail Service pharmacy, and a Specialty Drug Pharmacy Network. The PBM, in consultation with Us, also provides services to promote and enforce the appropriate use of pharmacy benefits, such as review for possible excessive use; recognized and recommended dosage regimens; Drug interactions or Drug/pregnancy concerns.

You may request a copy of the covered Prescription Drug list by calling the Customer Service telephone number on the back of your Identification Card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage.

Prescription Drugs, unless otherwise stated below, must be Medically Necessary and not Experimental/Investigative, in order to be Covered Services. For certain Prescription Drugs, the prescribing Physician may be asked to provide additional information before the PBM and/or the Plan can determine Medical Necessity. The Plan may, in its sole discretion, establish quantity and/or age limits for specific Prescription Drugs, which the PBM will administer. Covered Services will be limited based on Medical Necessity, quantity and/or age limits established by the Plan, or utilization guidelines.

Prior Authorization may be required for certain Prescription Drugs (or the prescribed quantity of a particular Drug). Prior Authorization helps promote appropriate utilization and enforcement of guidelines for Prescription Drug benefit coverage. At the time you fill a prescription, the Network pharmacist is informed of the Prior Authorization requirement through the pharmacy's computer system. The PBM uses pre-approved criteria, developed by Our Pharmacy and Therapeutics Committee which is reviewed and adopted by Us. We, or the PBM may contact your Provider if additional information is required to determine whether Prior Authorization should be granted. We communicate the results of the decision to both you and your Provider.

If Prior Authorization is denied, you have the right to appeal through the appeals process outlined in the Member Grievances section of this Certificate.

For a list of the current Drugs requiring Prior Authorization, please contact the Customer Service telephone number on the back of your ID card. The covered Prescription Drug list is subject to periodic review and amendment. Inclusion of a Drug or related item on the covered Prescription Drug list is not a guarantee of coverage under your Certificate. Refer to the Prescription Drug benefit sections in this Certificate for information on coverage, limitations and exclusions. Your Provider or Network Pharmacist may check with Us to verify covered Prescription Drugs, any quantity and/or age limits, or applicable Brand or Generic Drugs recognized under the Plan.

Therapeutic Substitution of Drugs is a program approved by Us and managed by the PBM. This is a voluntary program designed to inform Members and Physicians about possible alternatives to certain prescribed Drugs. We, or the PBM, may contact you and your prescribing Physician to make you aware of substitution options. Therapeutic substitution may also be initiated at the time the prescription is dispensed. Only you and your Physician can determine whether the therapeutic substitute is appropriate for you. For questions or issues involving therapeutic Drug substitutes, call the Customer Service telephone number on the back of your ID card. The therapeutic Drug substitutes list is subject to periodic review and amendment.

Step Therapy

Step therapy protocol means that a Member may need to use one type of medication before another. The PBM monitors some Prescription Drugs to control utilization, to ensure that appropriate prescribing guidelines are followed, and to help Members access high quality yet cost effective Prescription Drugs. If a Physician decides that the monitored medication is needed the Prior Authorization process is applied.

Specialty Pharmacy Network

The PBM's Specialty Pharmacy Network is available to members who use Specialty Drugs.

"Specialty Drugs" are Prescription Legend Drugs which:

- Are only approved to treat limited patient populations, indications or conditions; or
- Are normally injected, infused or require close monitoring by a physician or clinically trained individual; or

- Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

Network Specialty Pharmacies may fill both retail and mail service Specialty Drug Prescription Orders, subject to a 30 day supply for Retail and Mail Service, and subject to the applicable Coinsurance or Copayment shown in the Schedule of Benefits.

Network Specialty Pharmacies have dedicated patient care coordinators to help you manage your condition and offer toll-free twenty-four hour access to nurses and registered Pharmacists to answer questions regarding your medications.

You may obtain a list of the Network Specialty Pharmacies, and covered Specialty Drugs, by calling the Customer Service telephone number on the back of your ID card, or review the lists on Our website at www.anthem.com.

Covered Prescription Drug Benefits

- Prescription Legend Drugs.
- Specialty Drugs.
- Injectable insulin and syringes used for administration of insulin.
- Oral contraceptive Drugs are covered when obtained through an eligible Pharmacy. Certain contraceptives are covered under the "Preventive Care" benefit. Please see that section for further details.
- Certain supplies and equipment obtained by Mail Service or from a Network Pharmacy (such as those for diabetes and asthma) are covered without any Copayment/Coinsurance. Contact Us to determine approved covered supplies. If certain supplies, equipment or appliances are not obtained by Mail Service or from a Network Pharmacy then they are covered as Medical Supplies, Equipment and Appliances instead of under Prescription Drug benefits.
- Injectables.
- Medical food that is Medically Necessary and prescribed by a Physician for the treatment of an inherited metabolic disease. Medical food means a formula that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and formulated to be consumed or administered enterally under the direction of a Physician.
- Smoking Cessation Prescription Drugs (no over the counter drugs).
- Treatment of Onchomycosis (toenail fungus).

Non Covered Prescription Drug Benefits (please also see the Exclusions section of this Benefit Booklet for other non Covered Services)

- Over the counter drugs

- Over the counter vitamins
- Prescription vitamins (covered if treating a medical condition)
- Retin-A (covered if treating a medical condition)
- Diet Pills (Anorexiants)
- Fluoride Supplements
- Experimental/ Investigative drugs
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Off label use, except as otherwise prohibited by law or as approved by Us or the PBM.
- Oral immunizations and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services.

Deductible/Coinsurance/Copayment

Each Prescription Order may be subject to a Deductible and Coinsurance/Copayment. If the Prescription Order includes more than one covered Drug, a separate Coinsurance/Copayment will apply to each covered Drug. Your Prescription Drug Coinsurance/Copayment will be the lesser of your scheduled Copayment/Coinsurance amount or the Maximum Allowable Amount. Please see the Schedule of Benefits for any applicable Deductible and Coinsurance/Copayment. If you receive Covered Services from a Non-Network Pharmacy, a Deductible and Coinsurance/Copayment amount may also apply.

Days Supply

The number of days supply of a Drug which you may receive is limited. The days supply limit applicable to Prescription Drug coverage is shown in the Schedule of Benefits. If you are going on vacation and you need more than the days supply allowed for under this Certificate, you should ask your Pharmacist to call the PBM and request an override for one additional refill. This will allow you to fill your next prescription early. If you require more than one extra refill, please call the Customer Service telephone number on the back of your Identification Card.

Tiers

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, or third "tier" Drug. The determination of tiers is made by Us based upon clinical information, and where appropriate the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and where appropriate certain clinical economic factors.

- Tier 1 includes Generic Prescription Drugs.
- Tier 2 includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are preferred relative to other Drugs.
- Tier 3 includes Brand Name or Generic Drugs that based upon their clinical information, and where appropriate, cost considerations are not preferred relative to other Drugs in lower tiers.

Half-Tablet Program

The Half-Tablet Program will allow Members to pay a reduced Copayment on selected "once daily dosage" medications. The Half-Tablet Program allows a Member to obtain a 30-day supply (15 tablets) of the higher strength medication when written by the Physician to take "$\frac{1}{2}$ tablet daily" of those medications on the approved list. The Pharmacy and Therapeutics Committee will determine additions and deletions to the approved list. The Half-Tablet Program is strictly voluntary and the Member's decision to participate should follow consultation with and the agreement of his/her Physician. To obtain a list of the products available on this program contact the number on the back of your ID Card.

Payment of Benefits

The amount of benefits paid is based upon whether you receive the Covered Services from a Network Pharmacy, including a Network Specialty Pharmacy, a Non-Network Pharmacy, or the PBM's Mail Service Program. It is also based upon which Tier We have classified the Prescription Drug or Specialty Drug. Please see the Schedule of Benefits for the applicable amounts, and for applicable limitations on number of days supply.

We retain the right at Our discretion to determine coverage for dosage formulations in terms of covered dosage administration methods (for example by mouth, injections, topical or inhaled) and may cover one form of administration and exclude or place other forms of administration on other Tiers.

The amounts for which you are responsible are shown in the Schedule of Benefits. No payment will be made by Us for any Covered Service unless the negotiated rate exceeds any applicable Deductible and/or Copayment/Coinsurance for which you are responsible.

Your Copayment(s), Coinsurance and/or Deductible amounts will not be reduced by any discounts, rebates or other funds received by the PBM and/or the Plan from Drug manufacturers or similar vendors. For Covered Services provided by a Network or Specialty Drug Network Pharmacy or through the PBM's Mail Service, you are responsible for all Deductibles and/or Copayment/Coinsurance amounts.

For Covered Services provided by a Non-Network Pharmacy, you will be responsible for the amount(s) shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount.

How to Obtain Prescription Drug Benefits

How you obtain your benefits depends upon whether you go to a Network or a Non-Network Pharmacy.

Network Pharmacy - Present your written Prescription Order from your Physician, and your Identification Card to the pharmacist at a Network Pharmacy. The Pharmacy will file your claim for you. You will be charged at the point of purchase for applicable Deductible and/or Copayment/Coinsurance amounts. If you do not present your Identification Card, you will have to pay the full retail price of the prescription. If you do pay the full charge, ask your pharmacist for an itemized receipt and submit it to Us with a written request for refund.

Specialty Drugs - You or your Physician can order your Specialty Drugs directly from a Specialty Network Pharmacy, simply call the number on the back of your Identification card. If you or your Physician orders your Specialty Drugs from a Specialty Network Pharmacy you will be assigned a patient care coordinator who will work with you and your Physician to obtain Prior Authorization and to coordinate the shipping of your Specialty Drugs directly to you or your Physician's office. Your patient care coordinator will also contact you directly when it is time to refill your Specialty Drug Prescription.

Non-Network Pharmacy - You are responsible for payment of the entire amount charged by the Non-Network, including a Non-Network Specialty Pharmacy. You must submit a Prescription Drug claim

form for reimbursement consideration. These forms are available from Us, the PBM, or from the Group. You must complete the top section of the form and ask the Non-Network Pharmacy to complete the bottom section. If for any reason the bottom section of this form cannot be completed by the pharmacist, you must attach an itemized receipt to the claim form and submit to Us or the PBM. The itemized receipt must show:

- name and address of the Non-Network Pharmacy;
- patient's name;
- prescription number;
- date the prescription was filled;
- name of the Drug;
- cost of the prescription;
- quantity of each covered Drug or refill dispensed.

You are responsible for the amount shown in the Schedule of Benefits. This is based on the Maximum Allowable Amount as determined by Anthem or the PBM's normal or average contracted rate with network pharmacies on or near the date of service.

The Mail Service Program - Complete the Order and Patient Profile Form. You will need to complete the patient profile information only once. You may mail written prescriptions from your Physician, or have your Physician fax the prescription to the Mail Service. Your Physician may also phone in the prescription to the Mail Service Pharmacy. You will need to submit the applicable Deductible, Coinsurance and/or Copayment amounts to the Mail Service when you request a prescription or refill.

6 NON-COVERED SERVICES/EXCLUSIONS

The following section indicates items which are excluded and are not Covered Services. Unless otherwise stated in this Plan's Benefits' Article, no benefits are provided for care and supplies related to:

- Human organ or tissue transplants other than as specifically stated as covered in the Benefits' Article.
- Artificial and/or mechanical hearts or ventricular and/or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This Exclusion includes services for implantation, removal and complications. This Exclusion does not apply to left ventricular assist devices when used as a bridge to a heart transplant.
- Artificial insemination.
- In vitro fertilization.
- Gamete intra fallopian transfer (GIFT).
- Immunizations except as specifically stated.

- Eye surgery to correct errors of refraction, such as near-sightedness, including without limitation radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
- Reversal of sterilization.
- Services or supplies prescribed, ordered or referred by or received from a member of your immediate family, including your spouse, child, brother, sister, parent, in-law, or self.
- Prescription, fitting, or purchase of eyeglasses or contact lenses except as otherwise specifically stated as a Covered Service. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intra-ocular surgery, or for soft contact lenses due to a medical condition.
- Hearing aids or examinations for prescribing or fitting them.
- Services, supplies, or charges which the Plan determines are not Medically Necessary or do not meet the Plan's medical policy, clinical coverage guidelines, or benefit policy guidelines.
- Custodial Care, Domiciliary or convalescent care, whether or not recommended or performed by a professional. This includes services at residential treatment facility. Residential treatment means individualized and intensive treatment in a residential facility, including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities. However, mental health and substance abuse residential treatment is a covered benefit.
- Dental treatment, regardless of origin or cause, except as specified elsewhere in this Plan's Benefits' Article. "Dental treatment" includes but is not limited to: Preventive care, diagnosis, treatment of or related to the teeth, jawbones (except that TMJ is a Covered Service as stated in this Plan's Benefits' Article) or gums, including but not limited to: extraction, restoration and replacement of teeth;
    - Medical or surgical treatments of dental conditions; and
    - Services to improve dental clinical outcomes.
- Treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service.
- Dental implants.
- Dental braces.
- Dental x rays, supplies & appliances and all associated expenses, including hospitalization and anesthesia, except as required by law. The only exceptions to this are for any of the following:
    1. transplant preparation;
    2. initiation of immunosuppresives; or
    3. direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.
- Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Health Care benefit as specifically stated in this Plan's Benefits' Article.

- Routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
    1. cleaning and soaking the feet;
    2. applying skin creams in order to maintain skin tone; or
    3. other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- Surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
- Any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Worker's Compensation Act or other similar law. If Worker's Compensation Act benefits are not available to you, then this Exclusion does not apply. This exclusion applies if you receive the benefits in whole or in part. This exclusion also applies whether or not you claim the benefits or compensation. It also applies whether or not you recover from any third party.
- Examinations relating to research screenings.
- Developmental delays except for Pervasive Developmental Disorders (including Asperger's syndrome and autism) as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Conditions of the American Psychiatric Association, learning disabilities, hyperkinetic syndromes, or mental retardation (except for Prescription Drugs).
- Illness or injury that occurs as a result of any act of war, declared or undeclared while serving in the armed forces.
- Services and supplies for which you have no legal obligation to pay in the absence of this or like coverage.
- Services and supplies incurred prior to your Effective Date.
- Services and supplies incurred after the termination date of this coverage except as specified elsewhere.
- Services or supplies provided by a sanitarium, or rest cures.
- Services or supplies furnished by any person or institution acting beyond the scope of her/his/its license.
- Plan benefits to the extent that the services are a Medicare Part A or Part B liability.
- Services and supplies received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group.
- Services and supplies to the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- Mileage, lodging and meals costs, and other Member travel related expenses, except as authorized by the Plan or specifically stated as a Covered Service. Services or supplies if the Plan does not state that benefits are provided for them.
- Telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or authorized by the Plan.

- Missed or canceled appointments.
- Completion of claim forms or charges for medical records or reports unless otherwise required by law.
- Recreation or diversional therapy.
- The cost of materials used in any Occupational Therapy.
- Personal hygiene environmental control, or convenience items including but not limited to: air conditioners, humidifiers, physical fitness equipment; personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals; charges for failure to keep a scheduled visit; for non-medical self-care except as otherwise stated; purchase or rental of supplies for common household use, such as exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds, treadmill or special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program; for a health spa or similar facility.
- Hospitalization for environmental change or Provider charges connected with prescribing an environmental change.
- Weight loss programs whether or not they are under medical or Physician supervision except as specifically listed as covered in this Plan's Benefits' Article. Weight loss programs for medical reasons are also excluded, except certain surgical treatments of morbid obesity as required by law are covered. Weight loss programs include but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) or fasting programs.
- The treatment of abuse of nicotine from tobacco or other sources, except for nicotine substitutes, which require a prescription under federal law.
- Stand-by charges of a Physician.
- Sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
- Drugs in quantities which exceed the limits established by the Plan.
- The Prescription Drug Copayment/Coinsurance portion of the Pharmacy Benefits Manager.
- Membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
- Diagnostic testing or treatment related to infertility.
- Marital counseling.
- Services and supplies received from an individual or entity that is not a Provider, as defined in this Plan's Benefits' Article, or recognized by the Plan.
- A condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.

- Services which are performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
- Services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
- Expenses incurred at a health spa or similar facility.
- Self-help training and other forms of non-medical self care, except as otherwise provided herein.
- Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, or for licensing.
- Services and supplies for Skilled Nursing Facilities.

- **EXPERIMENTAL/INVESTIGATIVE SERVICES**

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

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

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

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

  - the scientific evidence is conclusory concerning the effect of the service on health outcomes;

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

The information considered or evaluated by the Plan to determine whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Plan has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

- Care required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.
- Court ordered testing or care unless Medically Necessary.
- Charges in excess of the Maximum Allowable Amount.
- Procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve your appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of your skin or to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts), except benefits are provided for a reconstructive service performed to correct a physical functional impairment of any area caused by disease, trauma, congenital anomalies, or previous therapeutic process. Reconstructive services are payable only if the original procedure would have been a

Covered Service under this Plan. Other reconstructive services are not covered except as otherwise required by law. Complications directly related to cosmetic services treatment or surgery are not covered.

- Vision orthoptic training.
- Care received in an emergency room which is not Emergency Care, except as specified as covered.
- Chiropractic services rendered in the home as part of Home Care Services.
- Alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.
- Hiring, or the services of, a surrogate mother.
- Surgical treatment of gynecomastia.
- Treatment of hyperhydrosis (excessive sweating).
- Any service for which the Member is responsible under the terms of this Plan to pay a Copayment or Coinsurance and the Copayment or Coinsurance is waived by a non-Network Provider.
- Human Growth Hormone for children born small for gestational age. It is only a Covered Service in other situations when allowed by the Plan through Prior Authorization.
- Elective abortions.
- Prescriptions Drugs, except as provided through the Pharmacy Benefits Manager.
- Any medications dispensed in a physician's office.
- Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.

7 ELIGIBILITY AND ENROLLMENT

You have coverage provided under this Certificate because of your employment with/membership with/retirement from the Group. You must satisfy certain requirements to participate in the Group's benefit plan. These requirements may include probationary or waiting periods and Actively At Work standards as determined by the Group or state and/or federal law and approved by Us.

Your Eligibility requirements are described in general terms below. For more specific eligibility information, see your Human Resources or Benefits Department.

Eligibility

1. All active full-time (37.5 hours per week) employees and their eligible “dependents”.
2. All appointed or elected officials and their eligible “dependents”.
3. Employees eligible under the Short and Long Term Disability Program remain eligible during the period of disability.
4. "Dependent” means:
   a. Spouse of an employee;
   b. The Subscriber or the Subscriber’s spouse’s natural children, newborn and legally adopted children, stepchildren, children for whom the Subscriber or the Subscriber’s spouse is a legal guardian, the Subscriber or Subscriber’s spouse’s grandchildren or other blood relatives, or children who the Group has determined are covered under a “Qualified Medical Child Support Order” as defined by ERISA or any applicable state law.
      All enrolled eligible children will continue to be covered until the age limit listed in the Schedule of Benefits.
      Eligibility will be continued past the age limit only for those already enrolled Dependents who cannot work to support themselves due to physical or mental disability. The Dependent’s disability must start before the end of the period they would become ineligible for coverage. The Plan must certify the Dependent’s eligibility. The Plan must be informed of the Dependent’s eligibility for continuation of coverage within 120 days after the Dependent would normally become ineligible.
5. A group health coverage program that is equal to that offered active employees shall be provided by the State for each “Retired Legislator” who meets the following:
   a. Is no longer a member of the General Assembly;
   b. Who served as a legislator for at least 10 years.
      A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator’s Spouse covered under the health insurance program. In addition, the surviving Spouse of a legislator who has died may elect to participate in the group health insurance program if all of the following apply:
      1. The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the date of the legislator’s death;
      2. The surviving Spouse files a written request for insurance coverage with the employer;
      3. The surviving Spouse pays an amount equal to the employer’s and employee’s premium for the group health coverage for an active employee.
         The eligibility of the retired legislator’s Spouse, or a surviving Spouse of a legislator for group health coverage is not affected by the death of the retired legislator and is not affected by the retired legislator’s eligibility for Medicare. The Spouse’s eligibility ends on the earliest of the following:
         1. When the employer terminates the health coverage program;
         2. The date of the Spouse’s remarriage;

      IC 5-10-8-8.2 Former Legislators

      Sec. 8.2 (a) As used in this section, "former legislator" means a former legislator or spouse of a former legislator; or

1. is:

A. a dependent child, stepchild, foster child, or adopted child of a former legislator or spouse of a former legislator; or

B. a child who resides in the home of a former legislator who has been appointed legal guardian of the child; and

2. is:

A. less than twenty-six (26) years of age;

B. at least twenty-six (26) years of age, incapable of self-sustaining employment by reason of mental or physical disability, and is chiefly dependent on a former legislator or spouse of a former legislator for support and maintenance.

6. "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

   a. Must retire before January 1, 2007
   b. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
   c. Must have completed twenty (20) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement;
   d. Must have fifteen (15) years of participation in a retirement fund.

7. "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

   i. Must retire after December 31, 2006.
   ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
   iii. Must have completed fifteen (15) years of public service, ten (10) years of which must be continuous State service immediately preceding retirement.

8. "Retirees" meeting the following criteria will continue to be eligible until they become eligible for Medicare:

   i. Must have been employed as a teacher in a State institution under IC 11-10-5, IC 12-24-3, IC 16-33-3, or IC 16-33-4;
   ii. Must have reached age fifty-five (55) upon retirement but who is not eligible for Medicare;
   iii. Must have fifteen (15) years of service credit as a participant in the retirement fund of which the employee is a member on or before the employee's retirement date; or must have completed ten (10) years of service credit as a participant in the retirement fund of which the employee is a member immediately before the employee's retirement;

9. A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Judge" who meets the following:

   a. Retirement date is after June 30, 1990;
   b. Will have reached the age of sixty-two (62) on or before retirement date;
   c. Is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.;
   d. Who has at least eight (8) years of service credit as a participant in the Judge's retirement fund, with at least eight (8) years of service credit completed immediately preceding the Judge's retirement.

10. A group health coverage program that is equal to that offered active employees shall be provided by the State for each "Retired Prosecuting Attorney" who meets the following:
    a. Who is a retired participant under the Prosecuting Attorney's Retirement fund;
    b. Whose retirement date is after January 1, 1990;
    c. Who is at least sixty-two (62) years of age;
    d. Who is not eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; and
    e. Who has at least ten (10) years of service credit as a participant in the Prosecuting Attorneys retirement fund, with at least ten (10) years of service credit completed immediately preceding the participant's retirement.
11. Retirees eligible under subsections 6 - 10 must file a written request for the coverage within ninety (90) days after retirement. The Spouse's subsequent eligibility to continue insurance under the surviving Spouse's eligibility end on the earliest of the following:
    a. Twenty-four (24) months from the date the deceased Retirees coverage is terminated. At the end of the period the Spouse would be eligible to remain covered until the end of the maximum period under COBRA;
    b. When the Spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.
    c. The end of the month following remarriage; or
    d. As otherwise provided in I.C. 5-10-8-8(g).
12. Employee on a leave of absence for ninety (90) days or less and out of pay status
13. An employee on family leave
14. Retirees eligible under IC 5-10-12.
15. A former legislator, dependent, or Spouse as defined and pursuant to the conditions set forth in IC 5-10-8-8.2.
16. All active and retired full-time and part-time employees, elected or appointed officers and officials of a local unit of government that elect to provide health coverage under this plan. A local unit of government is defined as follows:
    a. A city, town, county, township, public library, or school corporation
    b. Any board, commission, department, division, authority, institution, establishment, facility, or governmental unit under the supervision of either the state or a city, town, county, township, public library, or school corporation, having a payroll in relation to persons it immediately employs, even if it is not a separate taxing unit.
17. As otherwise provided by Act of the Indiana General Assembly.

Effective Date Of Your Coverage

"For specific information concerning your Effective Date of coverage under this Plan, you should see your Human Resources or benefits department."

Coverage for a newborn child is effective from the moment of birth. Covered Services include the treatment of any injury or illness such as congenital deformity, hereditary complication, premature birth, and routine nursery care. Newborn must be formally added to Employee's policy through "family status" change process.

Newborn Infant Coverage

The benefits payable for covered Dependent children shall be paid for a sick or injured newborn infant of a Covered Person for the first 31 days of his or her life. The coverage for newly adopted children will be the same as for other covered Dependents. The coverage for the newborn infant or newly adopted child consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Coverage for the newborn infant or newly adopted child shall include, but not be limited to, benefits for Inpatient or Outpatient expenses arising from medical and dental treatment (including orthodontic and oral surgery treatment) involved in the management of birth defects known as cleft lip and cleft palate.

The coverage required for a newly adopted child:

1. Is effective upon the earlier of:
   - **a)** The date of placement for the purpose of adoption; or
   - **b)** The date of the entry of an order granting the adoptive parent custody of the child for purpose of adoption;
2. Continues unless the placement is disrupted prior to legal adoption and the child is removed from placement; or
3. Continues unless required action as described below is not taken.

To be covered beyond the first 31 days, the newborn or newly adopted child must be added to the Covered Person's Plan Enrollment within the first 31 days after birth or adoption.

If the Member must change to coverage with a higher fee to add the child, the Member will be liable for the higher fee for the entire period of the child's coverage, including the first 31 days.

Qualified Medical Child Support Order/Court Ordered Health Coverage

If you are required by a qualified medical child support order or court order, as defined by ERISA and/or applicable state law, to enroll your child under this Certificate, We will permit your child to enroll without regard to any enrollment limits and shall provide the benefits of this Certificate in accordance with the applicable requirements of such order. A child's coverage under this provision will not extend beyond the Dependent age limit. Any claims payable under this Certificate will be paid to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Federal Laws Related To Your Coverage

In the past few years, Congress has passed several laws that have affected our group health plans. These laws are designed to reduce Medicare expenditures by requiring that active employees and/or their Dependents who are either age 65 or over, or disabled to elect either:

a) our group health Plan, or

b) Medicare as their primary coverage.

The preference is option (a) since option (b) would require the discontinuance of the group medical Plan. In addition, Medicare no longer requires enrollment in the Part B Supplemental Medical Insurance Benefit for which there is a charge so long as you remain covered under our group medical Plan.

Special Enrollment/Special Enrollees

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents in the Plan, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If the Plan receives an application to add your Dependent or an Eligible Person and Dependent more than 31 days after the qualifying event, the Plan will not be able to enroll that person until the Employer's next Open Enrollment.

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

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

The Employee or Dependent must request Special Enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination. If the Plan receives an application to add your Dependent or an Eligible Person and Dependent more than 60 days after the loss of Medicaid/CHIP or of the eligibility determination, the Plan will not be able to enroll that person until the Employer's next Open Enrollment.

Application forms are available from the Employer.

8 CHANGES IN COVERAGE: TERMINATION, CONTINUATION & CONVERSION

Individual Termination

Your coverage will terminate on the earliest of the following dates:

- On the date the group Plan is terminated.
- On the last day of the period for which Premiums have been paid, if the Group fails to pay the required Premiums for you, except when resulting from clerical mistake or inadvertent error.
- On the last day of the period for which Premiums have been paid in which you leave or are dismissed from employment.
- On the date your Dependent(s) cease(s) to be an eligible Dependent.
- Upon the date of your death, coverage for your Dependents shall terminate at the end of the period for which Premiums have been paid.

Reinstatement

You will not be reinstated automatically if coverage is terminated. Re-application is necessary, unless termination resulted from inadvertent clerical error. No additions or terminations of membership will be processed during the time your or the Group's request for reinstatement is being considered by Us. Your coverage shall not be adversely affected due to the Group's clerical error. However, the Group is liable to Us if We incur financial loss as a result of the Group's clerical error.

Certification of Prior Creditable Coverage

If your coverage is terminated, you and your covered Dependents will receive a certification showing when you were covered under the Plan. You may need the document to qualify for another Group health Plan. You may also need the certification to buy, for yourself or your family, an individual policy that does not exclude coverage for medical conditions that were present before your enrollment. Certifications may be requested within 24 months of losing coverage.

You may also request a certification be provided to you at any other time, even if you have not lost coverage under this plan. If you have any questions, contact the customer service telephone number listed on the back of your Identification Card.

Continuation

Federal Continuation of Coverage (COBRA)

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

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

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of health coverage under the Group's health plan when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Group's health plan is lost because of the qualifying event. Under the Group's health plan, qualified beneficiaries who elect COBRA continuation coverage may or may not be required to pay for COBRA continuation coverage. Contact the Group for Premium payment requirements.

If you are a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's health plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a Subscriber, you will become a qualified beneficiary if you lose your coverage under the Group's health plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Group's health plan because any of the following qualifying events happens:

- The parent-Subscriber dies;
- The parent-Subscriber's hours of employment are reduced;
- The parent-Subscriber's employment ends for any reason other than his or her gross misconduct;
- The parent-Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Group's health plan as a "Dependent child."

If Your Group Offers Retirement Coverage

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Group, and that bankruptcy results in the loss of coverage of any retired Subscriber covered under the Group's health plan, the retired Subscriber will become a qualified beneficiary with respect to the bankruptcy. The retired Subscriber's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under Group's health plan.

When is COBRA Coverage Available

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

You Must Give Notice of Some Qualifying Events

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

How is COBRA Coverage Provided

Once the Group receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How Long Will Continuation Coverage Last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued only for up to a total of 18 months. In the case of losses of coverage due to the Subscriber's death, divorce or legal separation, the Subscriber's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Group's health plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement.

How Can You Extend The Length of COBRA Continuation Coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Group of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

- **Disability**

  An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. You must provide the SSA determination of your disability to the Group within 60 days of receipt. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Group of that fact within 30 days after SSA's determination.

- **Second Qualifying Event**

  An 18-month extension of coverage will be available to spouses and Dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered Subscriber, divorce or separation from the covered Subscriber, the covered Subscriber's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Group's health plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Group

within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

Trade Act of 1974

Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their Group health plan coverage ended.

If you, the Subscriber, qualify for assistance under the Trade Act of 1974, you should contact the Group for additional information. You must contact the Group promptly after qualifying for assistance under the Trade Act of 1974 or you will lose these special COBRA rights.

Premiums and the End of COBRA Coverage

Premium will be no more than 102% of the Group rate (unless your coverage continues beyond 18 months because of a disability. In that case, premium in the 19th through 29th months may be 150% of the Group rate).

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- the Group ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Group would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

If You Have Questions

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

Indiana Public Employee Continuation of Coverage

If you are covered through a Group that is a local unit public employer, as defined by Indiana law, you may be eligible for continuation of coverage under this Plan beyond the date your coverage would otherwise end. Please see your Group's Human Resources or benefits department for further information concerning your eligibility for continuation of coverage.

Continuation of Coverage Due To Military Service

In the event you are no longer Actively At Work due to military service in the Armed Forces of the United States, you may elect to continue health coverage for yourself and your Dependents (if any) under this Certificate in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

"Military service" means performance of duty on a voluntary or involuntary basis, and includes active duty, active duty for training, initial active duty for training, inactive duty training, and full-time National Guard duty.

You may elect to continue to cover yourself and your eligible Dependents (if any) under this Certificate by notifying your employer in advance and payment of any required contribution for health coverage. This may include the amount the Employer normally pays on your behalf. If Your military service is for a period of time less than 31 days, You may not be required to pay more than the active Member contribution, if any, for continuation of health coverage.

If continuation is elected under this provision, the maximum period of health coverage under this Certificate shall be the lesser of:

- The 24-month period beginning on the first date of your absence from work; or
- The day after the date on which You fail to apply for or return to a position of employment.

Regardless whether you continue your health coverage, if you return to your position of employment your health coverage and that of your eligible Dependents (if any) will be reinstated under this Certificate. No exclusions or waiting period may be imposed on you or your eligible Dependents in connection with this reinstatement unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

Family and Medical Leave Act of 1993

A Subscriber who is taking a period of leave under the Family and Medical Leave Act of 1993 (the Act) will retain eligibility for coverage during this period. The Subscriber and his or her Dependents shall not be considered ineligible due to the Subscriber not being Actively At Work.

If the Subscriber does not retain coverage during the leave period, the Subscriber and any eligible Dependents who were covered immediately prior to the leave may be reinstated upon return to work without medical underwriting and without imposition of an additional waiting period for Pre-Existing Conditions. To obtain coverage for a Subscriber upon return from leave under the Act, the Group must provide the Plan with evidence satisfactory to Us of the applicability of the Act to the Subscriber, including a copy of the health care Provider statement allowed by the Act.

9 HOW TO OBTAIN COVERED SERVICES

Network Providers are the key to providing and coordinating your health care services. Benefits are provided when you obtain Covered Service from Providers; however, the broadest benefits are provided for services obtained from a Primary Care Physician (PCP), Specialty Care Physician (SCP), or other Network Providers. **Services you obtain from any Provider other than a PCP, SCP or another Network Provider are considered a Non-Network Service, except for Emergency Care, Urgent Care, or as an Authorized Service.** Contact a PCP, SCP, other Network Provider, or Us to be sure that Prior Authorization and/or precertification has been obtained.

If a Non-Network Provider meets Our enrollment criteria and is willing to meet the terms and conditions for participation, that Provider has the right to become a Network Provider for the product associated with this Certificate.

Network Services and Benefits

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

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

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

For services rendered by Network Providers:

1. You will not be required to file any claims for services you obtain directly from Network Providers. Network Providers will seek compensation for Covered Services rendered from Us and not from you except for approved Coinsurance, Copayments and/or Deductibles. You may be billed by your Network Provider(s) for any non-Covered Services you receive or when you have not acted in accordance with this Certificate.

2. Health Care Management is the responsibility of the Network Provider.

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

Non-Network Services

Services which are not obtained from a PCP, SCP, or another Network Provider or not an Authorized Service will be considered a Non-Network Service. The only exception is Emergency Care and Urgent Care. In addition, certain services are not covered unless obtained from a Network Provider, see your Schedule of Benefits.

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

- The difference between the actual charge and the Maximum Allowable Amount plus any Deductible and/or Coinsurance/Copayments;
- Services that are not Medically Necessary;
- Non-Covered Services;
- Filing claims; and
- Higher cost sharing amounts.

Relationship of Parties (Plan - Network Providers)

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

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

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

Not Liable for Provider Acts or Omissions

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

Identification Card

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

10 CLAIMS PAYMENT

When you receive care through a Network Provider, you are not required to file a claim. This means that the provisions below, regarding Claim Forms and Notice of Claim, do not apply unless the Provider did not file the claim.

A claim must be filed for you to receive Non-Network Services benefits, but many Non-Network Hospitals, Physicians and other Providers will still submit your claim for you. If you submit the claim, use a claim form.

How Benefits Are Paid

Maximum Allowed Amount

General

This section describes how We determine the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Non-Network Providers is based on this/your Certificate's Maximum Allowed Amount for the Covered Service that You receive. Please see the BlueCard section for additional information.

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

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

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

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

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, We may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those

procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

Provider Network Status

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

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

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

For Covered Services You receive from a Non-Network Provider, the Maximum Allowed Amount for this Certificate will be one of the following as determined by Us:

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

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

Unlike Network Providers, Non-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds Our Maximum Allowed Amount. You are responsible for paying the

difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out of Pocket costs to You. Please call Customer Service for help in finding a Network Provider or visit Our website at www.anthem.com.

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

For Prescription Drugs: The Maximum Allowed Amount is the amount determined by Us using prescription drug cost information provided by the Pharmacy Benefits Manager (PBM).

Member Cost Share

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

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

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

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

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

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

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

- *The Non-Network anesthesiologist's charge for the service is $1200. The Maximum Allowed Amount for the anesthesiology service is $950; Your Coinsurance responsibility is 20% of $950, or $190 and the*

remaining allowance from Us is 80% of $950, or $760. You may receive a bill from the anesthesiologist for the difference between $1200 and $950. Provided the Deductible has been met, your total Out of Pocket responsibility would be $190 (20% Coinsurance responsibility) plus an additional $250, for a total of $440.

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

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

Authorized Services

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

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

Example:

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

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

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

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

Services Performed During Same Session

We may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to Our Maximum Allowable Amount. **If services are performed by Non Network Providers**, then you are responsible for any amounts charged in excess of Our Maximum Allowable Amount **with or without a referral or regardless if allowed as an Authorized Service**. Contact Us for more information.

Payment of Benefits

You authorize Us to make payments directly to Providers for Covered Services. Payments may also be made to, and notice regarding the receipt and/or adjudication of claims sent to, an Alternate Recipient (any child of a Subscriber who is recognized, under a Qualified Medical Child Support Order (QMSCO), as having a right to enrollment under the Group's Contract), or that person's custodial parent or designated representative. Any payments made by Us will discharge Our obligation to pay for Covered Services. You cannot assign your right to receive payment to anyone else, except as required by a "Qualified Medical Child Support Order" as defined by ERISA or any applicable state law.

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

Assignment

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

Notice of Claim

We are not liable under the Certificate, unless We receive written notice that Covered Services have been given to you. The notice must be given to Us within 90 days of receiving the Covered Services, and must have the data We need to determine benefits. If the notice submitted does not include sufficient data We need to process the claim, then the necessary data must be submitted to Us within the time frames specified in this provision or no benefits will be payable except as otherwise required by law.

If We have not received the information We need to process a claim, We will ask for the additional information necessary to complete the claim. You will receive a copy of that request for additional information, for your information. In those cases, We cannot complete the processing of the claim until the additional information requested has been received. We will make Our request for additional information within 30 days of Our initial receipt of the claim and will complete Our processing of the claim within 15 days after Our receipt of all requested information. An expense is considered incurred on the date the service or supply was given. **If We are unable to complete processing of a claim because you or your Provider fail to provide Us with the additional information within 60 days of Our request, the claim will be denied and you will be financially responsible for the claim.**

Failure to give Us notice within 90 days will not reduce any benefit if you show that the notice was given as soon as reasonably possible. No notice of an initial claim, nor additional information on a

claim can be submitted later than one year after the 90 day filing period ends, and no request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

Time Benefits Payable

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

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

Claim Forms

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

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

Member's Cooperation

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

Explanation of Benefits (EOB)

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

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

Out-of-Area Services

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

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

BlueCard® Program

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

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

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

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

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

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

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

11 HEALTH CARE MANAGEMENT

Your Plan includes the processes of Pre-Service, Concurrent and Retrospective Reviews to determine when services should be covered by your Plan. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Your Plan requires that Covered Services be Medically Necessary for benefits to be provided. When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

Prior Authorization: Network Providers are required to obtain prior authorization in order for you to receive benefits for certain services . Prior authorization criteria will be based on multiple sources including medical policy, clinical guidelines, and pharmacy and therapeutics guidelines. We may determine that a service that was initially prescribed or requested is not Medically Necessary if you have not previously tried alternative treatments which are more cost effective.

If you have any questions regarding the information contained in this section, you may call the Precertification telephone number on the back of your Identification Card or visit www.anthem.com.

Types of Requests:

Precertification – A required review of a service, treatment or admission for a benefit coverage determination which must be obtained prior to the service, treatment or admission start date. For emergency admissions, you, your authorized representative or Physician must notify Us within 48 hours of the admission or as soon as possible within a reasonable period of time. For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.

Predetermination – An optional, voluntary Prospective or Concurrent request for a benefit coverage determination for a service or treatment. We will review your Certificate to determine if there is an exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to determine whether the service meets the definition of Medical Necessity under this Certificate or is Experimental/Investigative as that term is defined in this Certificate.

Medical Review – A Retrospective review for a benefit coverage determination to determine the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that

did not require Precertification and did not have a Predetermination review performed. Medical Reviews occur for a service, treatment or admission in which We have a related clinical coverage guideline and are typically initiated by Us.

Most Network Providers know which services require Precertification and will obtain any required Precertification or request a Predetermination if they feel it is necessary. Your Primary Care Physician and other Network Providers have been provided detailed information regarding Health Care Management procedures and are responsible for assuring that the requirements of Health Care Management are met. The ordering Provider, facility or attending Physician will contact Us to request a Precertification or Predetermination review ("requesting Provider"). We will work directly with the requesting Provider for the Precertification request. However, you may designate an authorized representative to act on your behalf for a specific request. The authorized representative can be anyone who is 18 years of age or older.

Who is responsible for Precertification	
Services provided by a Network Provider	**Services provided by a BlueCard/Non-Network/Non-Participating Provider**
Provider	• Member is responsible for Precertification. • Member is financially responsible for service and/or setting that are/is not covered under this Certificate based on an Adverse Determination of Medical Necessity or Experimental/Investigative.

We will utilize Our clinical coverage guidelines, such as medical policy and other internally developed clinical guidelines, and preventative care clinical coverage guidelines, to assist in making Our Medical Necessity decisions. These guidelines reflect the standards of practice and medical interventions identified as appropriate medical practice. We reserve the right to review and update these clinical coverage guidelines periodically. Your Certificate and Group Contract take precedence over these guidelines.

You are entitled to receive, upon request and free of charge, reasonable access to any documents relevant to your request. To request this information, contact the Precertification telephone number on the back of your Identification Card.

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

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

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

You may determine whether a Provider is participating in certain programs by contacting customer service number on the back of your ID card.

Request Categories:

Urgent – a request for Precertification or Predetermination that in the opinion of the treating Provider or any Physician with knowledge of the Member's medical condition, could in the absence of such

care or treatment, seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function or subject the member to severe pain that cannot be adequately managed without such care or treatment.

Prospective – a request for Precertification or Predetermination that is conducted prior to the service, treatment or admission.

Concurrent - a request for Precertification or Predetermination that is conducted during the course of treatment or admission.

Retrospective - a request for Precertification that is conducted after the service, treatment or admission has occurred. Medical Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication of payment.

Decision and Notification Requirements

Timeframes and requirements listed are based on state and federal regulations. Where state regulations are stricter than federal regulations, We will abide by state regulations. If you reside and/or receive services in a state other than the state where your contract was issued other state-specific Health Care Management requirements may apply. You may call the telephone number on the back of your membership card for additional information.

Request Category	Timeframe Requirement for Decision and Notification
Precertification Requests	
Prospective Urgent	72 hours or 2 business days from the receipt of request whichever is less
Prospective Non-Urgent	2 business days from the receipt of the request
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours or 2 business days from the receipt of request whichever is less
Concurrent Non-Urgent	2 business days from the receipt of the request
Retrospective	2 business days from the receipt of the request
Predetermination Requests	

Prospective Urgent	72 hours from the receipt of request
Prospective Non-Urgent	15 calendar days from the receipt of the request
Concurrent Urgent when request is received more than 24 hours before the expiration of the previous authorization	24 hours from the receipt of the request
Concurrent Urgent when request is received less than 24 hours before the expiration of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Concurrent Non-Urgent	15 calendar days from the receipt of the request

If additional information is needed to make Our decision, We will notify the requesting Provider and send written notification to you or your authorized representative of the specific information necessary to complete the review. If We do not receive the specific information requested or if the information is not complete by the timeframe identified in the written notification, a decision will be made based upon the information in Our possession.

We will provide notification of Our decision in accordance with state and federal regulations. Notification may be given by the following methods:

- **Verbal:** oral notification given to the requesting Provider via telephone or via electronic means if agreed to by the Provider.
- **Written:** mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and the Member or authorized Member representative.

Precertification does not guarantee coverage for or payment of the service or procedure reviewed. For benefits to be paid, on the date you receive service:

1. you must be eligible for benefits;
2. premium must be paid for the time period that services are rendered;
3. the service or surgery must be a covered benefit under your Certificate;
4. the service cannot be subject to an exclusion under your Certificate, including but not limited to a Pre-Existing Condition limitation or exclusion; and
5. you must not have exceeded any applicable limits under your Certificate.

CARE MANAGEMENT

Care Management is a Health Care Management feature designed to help promote the timely coordination of services for Members with health-care related needs due to serious, complex, and/or chronic medical conditions. Our Care Management programs coordinate health care benefits and available services to help meet health-related needs of Members who are invited and agree to participate in the Care Management Program.

Our Care Management programs are confidential and voluntary. These programs are provided at no additional cost to You and do not affect Covered Services in any way. Licensed health care professionals trained in care management and familiar with the benefit plan provide these services.

For Members who meet program requirements/criteria and who agree to participate in a Care Management program, a licensed health care professional completes an assessment and develops an individualized plan designed to help meet their identified health care related needs. This is achieved through communication, and collaboration with the Member and/or Member's designated representative, treating Physician(s), and other Providers. The licensed health care professional remains in contact with the Member by telephone on a periodic basis to help accomplish the goals of the plan.

In addition to coordinating benefits, the licensed health care professional may assist with coordination of care with existing community-based programs and services to meet the Member's needs. Care coordination may include referrals to external agencies and available community-based programs and services.

Value-Added Programs

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

12 MEMBER GRIEVANCES

Grievances

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

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

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

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

You can also call Us at 1-800-408-5372 at any time to leave a voice mail message concerning a Grievance. Any messages you leave through this toll-free number will be returned on the following business day by a qualified Plan representative. We will also accept Grievances filed in writing, including by facsimile. If you wish to file your Grievance in writing, mail it to: Anthem Appeals, P.O. Box 105568, Atlanta, GA 30348-5568, ATTN: Appeals Specialist. Our facsimile number is 1-317-287-5968 if you wish to file your Grievance by fax.

Upon Our receipt of your written or oral Grievance at the above address or telephone number (or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us), an acknowledgment will be sent to you within 5 business days notifying you that you will receive a written response to the Grievance once an investigation into the matter is complete. Our acknowledgment may be oral for those Grievances We receive orally. All Grievances will be resolved by Us within a reasonable period of time appropriate to the medical circumstances but not later than 20 business days after they are filed (a Grievance is considered filed on the day it is received either in writing or over the phone at the above address or telephone number or at the address or telephone number provided for filing appeals on any adverse decision notice you receive from Us).

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

For Grievances concerning adverse certification decisions or the denial of any other Prior Authorization required by the Plan, a decision and written response will be sent no later than 20 business days after they are filed. No extensions for additional information will be taken without the permission of the Member. Within 5 business days after the Grievance is resolved, We will send a letter to you notifying you of the decision reached.

Appeals

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

decision concerning your Appeal.

Expedited Review

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

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

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

External Grievance

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

1. Your Appeal is regarding the following determinations made by Us or an agent of Ours regarding a service proposed by your treating Provider:
    - an adverse determination of appropriateness; or
    - an adverse determination of Medical Necessity; or
    - a determination that a proposed service is Experimental/Investigational; or
2. Your Appeal is regarding Our decision to rescind coverage under this Certificate; and
3. You or your representative request the External Grievance in writing within one hundred twenty (120) days after You are notified of the Appeal panel's decision concerning your Appeal; and
4. The service is not specifically excluded in this Certificate.

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

Grievance/Appeal Filing Time Limit

We expect that you will use good faith to file a Grievance or an Appeal on a timely basis. However, We will not review a Grievance if it is received by Us after the end of the calendar year plus 12 months have passed since the incident leading to your Grievance. We will accept Appeals filed within 60 days after you are notified of Our decision concerning your Grievance. We will accept External Grievance requests filed within 120 days after you are notified of Our Appeal decision.

Grievances and Appeals by Members of ERISA Plans

If you are covered under a Group plan which is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), you must file a Grievance prior to bringing a civil action under 29 U.S.C. 1132 §502(a). An Appeal of a Grievance decision is a voluntary level of review and need not be exhausted prior to filing suit. Any statutes of limitations or other defenses based upon timeliness will be tolled while an Appeal is pending. You will be notified of your right to file a voluntary Appeal if Our response to your Grievance is adverse. Upon your request, We will also provide you with detailed information concerning an Appeal, including how panelists are selected.

Notice To Members

Questions regarding your coverage should be directed to:

Anthem Insurance Companies, Inc.

1-800-408-5372

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

State of Indiana Department of Insurance

Consumer Services Division

311 W. Washington Street, Suite 300,

Indianapolis, Indiana 46204

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

Complaints can be filed electronically at www.in.gov/idoi

Legal Action

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

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

13 GENERAL PROVISIONS

Entire Contract

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

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

Form or Content of Certificate

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

Disagreement with Recommended Treatment

Each Member enrolls in the Plan with the understanding that they, in consultation with their Providers, are responsible for determining the treatment appropriate for their care. You may, for personal reasons, refuse to accept procedures or treatment recommended by your Providers. Providers may regard such refusal to accept their recommendations as incompatible with continuance of the Physician-patient relationship and as obstructing the provision of proper medical care. In this event, the Provider shall have no further responsibility to provide care to you, and We shall have no obligation to have Network Providers available who will render the care.

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

Circumstances Beyond the Control of the Plan

If circumstances arise that are beyond the control of the Plan, the Plan will make a good-faith gesture to arrange an alternative method of providing coverage. Circumstances that may occur, but are not within the control of the Plan, include but are not limited to, a major disaster or epidemic, complete or partial destruction of facilities, a riot, civil insurrection, labor disputes that are out of the control of the Plan, disability affecting a significant number of a Network Provider's staff or similar causes, or health care services provided under this Certificate are delayed or considered impractical. Under such circumstances, the Plan and Network Providers will provide the health care services covered by this Certificate as far as is practical under the circumstances, and according to their best judgment. However, the Plan and Network Providers will accept no liability or obligation for delay, or failure to provide or arrange health care services if the failure or delay is caused by events/circumstances beyond the control of the Plan.

Coordination Of Benefits

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

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

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

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

COB DEFINITIONS

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

1. Plan includes: Group and non group insurance contracts and subscriber contracts; Health maintenance organization (HMO) contracts; Uninsured arrangements of group or group-type coverage; Coverage under group or non group closed panel plans; Group-type contracts; Medical care components of long term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts (whether "fault" or "no fault"); Other governmental benefits, except for Medicaid or a government plan that, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

2. Plan does not include: Accident only coverage; Specified disease or specified accident coverage; Limited health benefit coverage; Benefits for non-medical components of long-term care policies; Hospital indemnity coverage benefits or other fixed indemnity coverage; School accident-type coverages covering grammar, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour or "to and from school" basis; and Medicare supplement policies.

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

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

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

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

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

The following are non Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If you are covered by 2 or more Plans that calculate their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement methods, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If you are covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If you are covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable expense for all Plans. However, if the Provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment will be the Allowable expense used by the Secondary Plan to determine its benefits.

5. The amount of any benefit reduction by the Primary Plan because you have failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admissions or services, and Network Provider arrangements.

6. The amount that is subject to the Primary high-deductible health plan's deductible, if We have been advised by you that all Plans covering you are high-deductible health plans and you intend to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986.

7. Any amounts incurred or claims made under the Prescription Drug program of this Plan.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

1. For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
   - The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
   - If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.
2. For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   - If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

- If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of 1. above will determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of 1. above will determine the order of benefits; or
- If there is no court decree assigning responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
  - The Plan covering the Custodial parent;
  - The Plan covering the spouse of the Custodial parent;
  - The Plan covering the non-custodial parent; and then
  - The Plan covering the spouse of the non-custodial parent.

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

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

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

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

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

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

Medicare

Any benefits covered under both this Certificate and Medicare will be paid pursuant to Medicare Secondary Payor legislation, regulations, and Centers for Medicare & Medicaid Services (CMS) guidelines, subject to federal court decisions. Federal law controls whenever there is a conflict among state law, Certificate provisions, and federal law.

Except when federal law requires the Plan to be the primary payor, the benefits under this Certificate for Members age 65 and older, or Members otherwise eligible for Medicare, do not duplicate any benefit for which Members are entitled under Medicare, including Parts B. Where Medicare is the responsible

payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to the Plan, to the extent the Plan has made payment for such services. For the purposes of the calculation of benefits, if the Member has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.

Physical Examination

When a claim is pending, We reserve the right to request a Member to be examined by an applicable Provider. This will be requested as often as reasonably required.

Workers' Compensation

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

Other Government Programs

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

Subrogation and Reimbursement

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

Subrogation

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

- We have the first priority for the full amount of benefits We have paid from any Recovery regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses and injuries.
- You and your legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Plan.

- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by you, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

- We are not responsible for any attorney fees, other expenses or costs without Our prior written consent. We further agree that the "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement

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

- You must reimburse Us to the extent of benefits We paid on your behalf from any Recovery.

- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.

- You and your legal representative must hold in trust for Us the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon your receipt of the Recovery. you must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by Us.

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

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

- In the event that you fail to disclose to Us the amount of your settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.

- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of your settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be your obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.

- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make you whole.

Your Duties

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

Right of Recovery

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

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

Relationship of Parties (Group-Member Plan)

Neither the Group nor any Member is the agent or representative of the Plan.

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

Anthem Blue Cross and Blue Shield Note

The Group, on behalf of itself and its participants, hereby expressly acknowledges its understanding that this Certificate constitutes a contract solely between the Group and Anthem Insurance Companies, Inc. dba Anthem Blue Cross and Blue Shield (Anthem), and that Anthem is an independent corporation licensed to use the Blue Cross and Blue Shield names and marks in the state of Indiana. The Blue Cross and Blue Shield marks are registered by the Blue Cross and Blue Shield Association, an association of

independently licensed Blue Cross and Blue Shield plans, with the U.S. Patent and Trademark Office in Washington, D.C. and in other countries. Further, Anthem is not contracting as the agent of the Blue Cross and Blue Shield Association or any other Blue Cross and/or Blue Shield plan or licensee. This paragraph shall not create any additional obligations whatsoever on the part of Anthem other than those obligations created under other provisions of this agreement.

Modifications

This Certificate allows the Group to make the Plan coverage available to eligible Members. However, this Certificate shall be subject to amendment, modification, and termination in accordance with any of its provisions, the Group Contract, or by mutual agreement between the Plan and the Group without the permission or involvement of any Member. Changes will not be effective until 30 days after We provide written notice to the Group about the change. By electing medical and Hospital coverage under the Plan or accepting the Plan benefits, all Members who are legally capable of entering into a contract, and the legal representatives of all Members that are incapable of entering into a contract, agree to all terms, conditions, and provisions in this Certificate.

Conformity with Law

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

Clerical Error

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

Policies and Procedures

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

Under the terms of the Group Contract, the Plan has the authority, in its sole discretion, to introduce or terminate from time to time, pilot or test programs for disease management or wellness initiatives which may result in the payment of benefits not otherwise specified in this Certificate. The Plan reserves the right to discontinue a pilot or test program at any time. The Plan will provide thirty (30) days advance written notice to the Group of the introduction or termination of any such program.

Waiver

No agent or other person, except an authorized officer of the Plan, has able to disregard any conditions or restrictions contained in this Certificate, to extend the amount of time for making a payment to the

Plan, or to bind the Plan by making any promise or representation or by giving or receiving any information.

Plan's Sole Discretion

The Plan may, in its sole discretion, cover services and supplies not specifically covered by the Certificate. This applies if the Plan determines such services and supplies are in lieu of more expensive services and supplies, which would otherwise be required for the care and treatment of a Member.

Reservation of Discretionary Authority

The following provision only applies where the interpretation of this Certificate is governed by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. 1001 et seq.

The Plan, or anyone acting on Our behalf, shall determine the administration of benefits and eligibility for participation in such a manner that has a rational relationship to the terms set forth herein. However, We, or anyone acting on Our behalf, has complete discretion to determine the administration of your benefits. Our determination shall be final and conclusive and may include, without limitation, determination of whether the services, care, treatment, or supplies are Medically Necessary, Experimental/Investigative, whether surgery is cosmetic, and whether charges are consistent with Our Maximum Allowable Amount. However, a Member may utilize all applicable complaint and appeals procedures.

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

14 DEFINITIONS

If a word or phrase in this Certificate have special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section.

If you need additional clarification on any of these definitions, please contact the customer service number located on the back of your ID Card or submit your question online at www.anthem.com.

Actively At Work – An employee who is capable of carrying out their regular job duties and who is present at their place of work. Additionally, Subscribers who are absent from work due to a health related absence or disability and those on maternity leave or scheduled vacation, are considered Actively At Work.

Appeal - A formal request by you or your representative for reconsideration of a decision not resolved to your satisfaction at the Grievance level. An Appeal involves review by an appointed panel composed of staff members of the Plan who did not previously render an opinion on the resolution of your Grievance.

Authorized Service(s) – A Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by Us to be paid at the Network level. The Member may be responsible for the difference between the Non-Network Provider's charge and the Maximum Allowable Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible. For more information, see the "Claims Payment" section.

Behavioral Health Conditions

- **Mental Health Condition** – A display of mental or nervous symptoms that are not a result of any physical or biological cause(s) or disorder(s).
- **Substance Abuse** - A condition that develops when an individual uses alcohol or other drug(s) in a way that damages their health and/or causes them to loose control of their actions.

Benefit Period – The length of time that We will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If your coverage ends before this length of time, then the Benefit Period also ends.

Benefit Period Maximum – The maximum that We will pay for specific Covered Services during a Benefit Period.

Brand Name Drug – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer's own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

Certificate – The document providing a summary of the terms of your benefits. It is attached to, and is a part of, the Group Contract. It is also subject to the terms of the Group Contract.

Copayment – A specific dollar amount of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. The Copayment does not apply to any Deductible that you are required to pay. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

Coinsurance - A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which you must pay. Coinsurance normally applies after the Deductible that you are required to pay. See the Schedule of Benefits for any exceptions.

Covered Services - Services, supplies or treatment as described in this Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Certificate is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto.
- Authorized in advance by Us if such Prior Authorization is required in this Certificate.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to you. The incurred date (for determining application of Deductible and other cost share amounts) for

an Inpatient admission is the date of admission except as otherwise specified in benefits after termination.

Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Transplant Procedure - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

Covered Transplant Services - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure within a Covered Transplant Benefit Period, including any Diagnostic evaluation for the purpose of determining a Member's appropriateness for a Covered Transplant Procedure.

Custodial Service or Care - Care primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which you must pay for before We will pay for those Covered Services in each Benefit Period.

Dependent – A Member of the Subscriber's family who is covered under the Certificate, as described in the "Eligibility and Enrollment" Section.

Diagnostic (Service/Testing) – A test or procedure performed on a Member, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for a Member who is not

displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services in the Covered Services section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because a Member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.

Effective Date – The date that a Subscriber's coverage begins under this Certificate. You must be Actively At Work on your Effective Date for your coverage to begin. If you are not Actively At Work on your Effective Date, your Effective Date changes to the date that you do become Actively At Work.

A Dependent's coverage also begins on the Subscriber's Effective Date.

Eligible Person – A person who meets the Group's requirements and is entitled to apply to be a Subscriber.

Emergency (Emergency Medical Condition) – An accidental traumatic bodily injury or other medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- place an individual's health in serious jeopardy;
- result in serious impairment to the individual's bodily functions; or
- result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care (Emergency Services) - A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

Enrollment Date – The day the Group or Member signs up for coverage or, when there is a waiting period, the first day of the waiting period (normally the date that employment begins).

Experimental/Investigative – Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be unproven. For how this is determined, see the "Non-Covered Services/Exclusions" section.

Expedited Review – The expedited handling of a Grievance or Appeal concerning Our denial of certification or coverage for a proposed (future) or ongoing service. Expedited Grievances and Appeals are available when your health condition is an Emergency or when time frames for non-Expedited Review could seriously jeopardize your life, health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed.

External Grievance - Your right to request external review of an Appeal determination made by the Appeals panel that is not acceptable to you. An External Grievance is conducted by an independent review organization. The independent review organization will assign a medical review professional who is board certified in the applicable specialty to resolve the External Grievance. The medical review professional who is assigned must not have a conflict of interest regarding the External Grievance issue itself or any of the interested parties. In making a determination on the External Grievance, the medical review professional is required to follow a standard of review that promotes evidence-based decision-making, relying on objective criteria, and is required to apply the terms of this Certificate.

Family Coverage – Coverage for the Subscriber and all eligible Dependents.

Formulary - The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Generic Drugs – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Grievance - Any expression of dissatisfaction made by you or your representative to the Plan or its affiliates in which you have the reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction. A Grievance is considered filed with the Plan on the day and time it is received. Grievances may include, but are not limited to, concerns about:

- a determination that a proposed service is not appropriate or Medically Necessary;
- a determination that a proposed service is Experimental/Investigative;
- the availability of Providers;
- the handling or payment of claims for health care services;
- matters pertaining to the contractual relationship between you and the Plan or the Group and the Plan;
- Our decision to rescind coverage under this Certificate.

Group – The employer, or other organization, that has entered into a Group Contract with the Plan.

Group Contract (or Contract) – The Contract between the Plan and the Group; It includes this Certificate, your application, any supplemental application or change form, your Identification Card, and any additional legal terms added by Us to the original Contract.

Identification Card / ID Card – A card issued by the Plan, showing the Member's name, membership number, and occasionally coverage information.

Inpatient – A Member who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. This does not apply to a Member who is placed under observation for fewer than 24 hours.

Late Enrollee – An Eligible Person whose enrollment did not occur on the earliest date that coverage can become effective under this Certificate, and who did not qualify for Special Enrollment.

Mail Service – The PBM's program which offers you a convenient means of obtaining maintenance medications by mail if you take Prescription Drugs on a regular basis. Covered Prescription Drugs are ordered directly from the licensed Pharmacy Mail Service which has entered into a reimbursement agreement with Us, and sent directly to your home.

Maximum Allowable Amount (Maximum Allowed Amount) - The maximum amount that We will allow for Covered Services You receive. For more information, see the "Claims Payment" section.

Medically Necessary/ Medical Necessity - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Us to be:

- Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Obtained from a Provider;

- Provided in accordance with applicable medical and/or professional standards;
- Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- The most appropriate supply, setting or level of service that can safely be provided to the Member and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Member's illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental/Investigative;
- Not primarily for the convenience of the Member, the Member's family or the Provider.
- Not otherwise subject to an exclusion under this Certificate.

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

Medicare - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

Member – A Subscriber or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the Plan and been covered by the required Premium payment; Members are sometimes called "you" or "your" in this Certificate.

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

Network Specialty Pharmacy – A Pharmacy which has entered into a contractual agreement or is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services and certain administrative functions to you for the Specialty Pharmacy Network.

Network Transplant Provider – A Provider that has been designated as a "center of excellence" by Us and/or a Provider selected to participate as a Network Transplant Provider by a designee. Such Provider has entered into a transplant provider agreement to render Covered Transplant Procedures and certain administrative functions to you for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

New FDA Approved Drug Product or Technology - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use.

New FDA Approved Drug Product or Technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed Drug product but new manufacturer: a product that duplicates another firm's already marketed Drug product (same active ingredient, formulation, or combination);
- Already marketed Drug product, but new use: a new use for a Drug product already marketed by the same or a different firm; or
- Newly introduced generic medication: generic medications contain the same active ingredient as their counterpart brand-named medications.

Non-Network Provider - A Provider who has not entered into a contractual agreement with Us for the Network associated with this Certificate. Providers who have not contracted or affiliated with Our designated Subcontractor(s) for the services they perform under this Certificate are also considered Non-Network Providers.

Non-Network Specialty Pharmacy – Any Pharmacy which has not entered into a contractual agreement nor is otherwise engaged by Us to render Specialty Drug Services, or with another organization which has an agreement with Us, to provide Specialty Drug services to you for the Specialty Pharmacy Network.

Non-Network Transplant Provider - Any Provider that has **NOT** been designated as a "center of excellence" by Us or has not been selected to participate as a Network Transplant Provider by a designee.

Open Enrollment – A period of enrollment designated by the Plan in which Eligible Persons or their Dependents can enroll without penalty after the initial enrollment; See Eligibility and Enrollment section for more information.

Out of Pocket Limit - A specified dollar amount of expense incurred by a Member and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Limit is reached for a Member and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Certificate and/or the Schedule of Benefits.

Outpatient - A Member who receives services or supplies while not an Inpatient.

Pharmacy and Therapeutics (P&T) Committee – A committee consisting of health care professionals, including Nurses, Pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of Drugs; determining the assignments of Drugs; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, prior authorization criteria, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

Plan (or We, Us, Our) – Anthem Insurance Companies, Inc., dba Anthem Blue Cross and Blue Shield which provides benefits to Members for the Covered Services described in this Certificate.

Premium – The charges that must be paid by the Subscriber or the Group to maintain coverage. This may be based on your age, depending on the Group's Contract with the Plan.

Prescription Order – A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug – A medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, "Caution: Federal law prohibits dispensing without a prescription." Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Certificate.

Primary Care Physician ("PCP") – A Network Provider who is a practitioner that specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Network Provider as allowed by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Member and is responsible for ongoing patient care.

Prior Authorization – The process applied to certain services, supplies, treatment, and certain Drugs and/or therapeutic categories to define and/or limit the conditions under which they will be covered. Prescription Drugs and their criteria for coverage are defined by the P&T Committee.

Provider – A duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities listed below. If you have a question about a Provider not shown below, please call the number on the back of your ID card.

- **Alcoholism Treatment Facility** - A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- **Alternative Care Facility** – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
  2. Surgery
  3. Therapy Services or rehabilitation.
- **Ambulatory Surgical Facility** - A facility, with an organized staff of Physicians, that:
  1. Is licensed as such, where required;
  2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  4. Does not provide Inpatient accommodations; and
  5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.
- **Athletic Trainer** – A person licensed under applicable Indiana state law providing physical medicine and rehabilitative services within their scope of practice.
- **Certified Advance Registered Nurse Practitioner**
- **Certified Nurse Midwife**
- **Certified Registered Nurse Anesthetist**
- **Certified Surgical Assistant**
- **Day Hospital** - A facility that provides day rehabilitation services on an Outpatient basis.
- **Dialysis Facility** - A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at your home. It is not a Hospital.

- **Drug Abuse Treatment Facility** - A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- **Home Health Care Agency** - A facility, licensed in the state in which it is located, which:

  1. Provides skilled nursing and other services on a visiting basis in the Member's home; and
  2. Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- **Home Infusion Facility** - A facility which provides a combination of:

  1. Skilled nursing services
  2. Prescription Drugs
  3. Medical supplies and appliances

  in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- **Hospice** - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.
- **Hospital** - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:

  1. Provides room and board and nursing care for its patients;
  2. Has a staff with one or more Physicians available at all times;
  3. Provides 24 hour nursing service;
  4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
  5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

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

  1. Nursing care
  2. Rest care
  3. Convalescent care
  4. Care of the aged
  5. Custodial Care
  6. Educational care
  7. Treatment of alcohol abuse
  8. Treatment of drug abuse

- **Laboratory (Clinical)**
- **Licensed Practical Nurse**

- **Licensed Professional Counselors**
- **Occupational Therapist**
- **Outpatient Psychiatric Facility** - A facility which mainly provides Diagnostic and therapeutic services for the treatment of Behavioral Health Conditions on an Outpatient basis.
- **Pharmacy** - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or a Non-Network Provider.
- **Physical Therapist**
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Behavioral Health Conditions. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Registered Nurse First Assistant**
- **Registered Nurse**
- **Registered Nurse Practitioner**
- **Regulated Physician's Assistant**
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Respiratory Therapist (Certified)**
- **Retail Health Clinic** - A facility that provides limited basic medical care services to Members on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:

  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. provides care supervised by a Physician;
  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial Provider or similar place.

- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- **Speech Therapist**
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
- **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

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

Service Area – The geographical area where Our Covered Services are available, as approved by state regulatory agencies.

Single Coverage – Coverage that is limited to the Subscriber only.

Special Enrollment – A period of enrollment in which certain Eligible Persons or their Dependents can enroll after the initial enrollment, typically due to an event such as marriage, birth, adoption, etc.

Specialty Care Physician (SCP) - A Network Provider, other than a Primary Care Physician, who provides services within a designated specialty area of practice.

Stabilize - The provision of medical treatment to you in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of your condition is not likely to result from or during any of the following:

- your discharge from an emergency department or other care setting where Emergency Care is provided to you; or
- your transfer from an emergency department or other care setting to another facility; or
- your transfer from a Hospital emergency department or other Hospital care setting to the Hospital's Inpatient setting.

Subcontractor – We may subcontract particular services to organizations or entities that have specialized expertise in certain areas. This may include but is not limited to Prescription Drugs and/or Behavioral Health services. Such subcontracted organizations or entities may make benefit determinations and/or perform administrative, claims paying, or customer service duties on Our behalf.

Subscriber - An employee or Member of the Group who is eligible to receive benefits under the Group Contract.

Therapy Services – Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

15 FOR QUESTIONS ABOUT BENEFITS, CLAIMS, ENROLLMENT, OR BILLINGS

CUSTOMER SERVICE NUMBER
Business Hours are 8:00 a.m. to 6:00 p.m.
Medical Questions - 1-877-814-9709

PRECERTIFICATION
1-877-814-4803

MENTAL HEALTH OR SUBSTANCE ABUSE PROGRAM
1-800-223-7723

EMPLOYEE ASSISTANCE PROGRAM
1-800-223-7723

PHARMACY NETWORK
1-800-662-0210

PLEASE HAVE YOUR IDENTIFICATION NUMBER READY WHEN YOU CALL

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